RELUCTANT WARRIORS: POLICE AS PAWNS IN THE WAR ON DRUGS, HOMELESSNESS, AND MENTAL HEALTH

By

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Abstract

Police agencies throughout Canada have been increasingly relied upon to respond to complex social issues, such as addictions, mental health, and homelessness, despite these concerns falling outside the traditional realm of criminal activity and public safety (Department of Justice Canada, 2018). Although police have a role in resolving these societal issues, this study posits that they should not be the primary agency when dealing with vulnerable populations. This study examines the causal factors that create stigmatisation toward vulnerable populations, particularly at the local government and community level, that has manifested into a criminal justice, rather than a health and wellbeing approach, to address community concerns. To examine these issues, calls for service data from the Royal Canadian Mounted Police in British Columbia were analyzed, followed by semi-structured qualitative interviews with 14 professionals working in the areas of criminal justice, health, and advocacy. Several related themes emerged from this analysis, including the need for: increased collaboration between police, social services, and health agencies; the reduction of barriers to implementing collaboration, the reduction of stigmatisation towards vulnerable populations; a re-assessment of the role of police toward vulnerable populations; increased investment into supports; and decriminalisation of illicit drugs providing that significant investment and policies are in place. The data and interviews indicate that police have become the default in responding to certain social concerns, causing them to become reluctant warriors against those suffering from mental health and addictions due to outdated policies that stigmatize and marginalize the very people they seek to protect.

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Dedication

This body of work is dedicated to my older brother Peter, who found himself a member of the vulnerable population referred to in this major paper following a serious brain injury in his teenaged years. I am grateful for an extended and caring family that guided him through many difficult years, especially our sister who finally managed to find him continuing support in a care facility. Without the care of family and dedicated support workers, I fear Peter would have been just another statistic in an ongoing battle against addictions, mental health, and homelessness. I am saddened that help did not come to him sooner, but encouraged that change is possible.

"How wonderful it is that nobody need wait a single moment before starting to improve the world" - Anne Frank

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Chapter 1: Introduction

In the mid 1930s, rumours of war abounded in Europe and modern society. Despite the emerging threat of Hitler's policies, appeasement was the flavour of the day, with a hope to prevent war at all costs, despite the suffering of other countries under the Nazi regime. Appeasement policies were predicated on outdated strategies and experiences of the previous world war that led to the misplaced belief that static defences, such as the Maginot line, would protect the interests of a peaceful Europe. The outdated policies did not work, and Europe was cast into an extended war that at the outset seemed hopeless with no path to victory. Were the allied nations to remain isolated from each other, that approach could very well have led to defeat, but that was not the case. Guided by a collective will to achieve a common purpose, the Allied Powers defeated the largest, most efficient war machine in modern history (Black, 2015). Collaboration, investment, and innovation were the key elements of victory, yet those lessons have not been fully embraced in a different type of war. The current war on drugs in North America continues to utilise enforcement and criminal justice measures focussed on the wrong enemy, as defined by the visible, vulnerable population, while at the same time failing to target the root causes of addictions, mental health, and homelessness.

In early 2020, the Angus Reid Institute reported that confidence in police was waning. The report was issued well before events that prompted certain groups, including various levels of government, to raise concerns around systemic racism leading to calls of defunding police agencies. The report stated that 48% of Canadians believed that crime had increased (Angus Reid Institute, 2020), even though only 15% of respondents indicated they had actually been a victim of crime during the reporting period. This indicated that perceptions of crime may be

higher than actual experienced crime. Similarly, growing public concerns with mental health and the visible manifestation of addictions cause concern for local communities that affects their citizens' perceptions of safety. Contrary to this perception, the people suffering from these afflictions tend to commit lower-level crimes, such as theft from auto, shoplifting, mischief, and disturbances (Boyd & Kerr, 2016; Centre for Addiction and Mental Health, 2019; Department of Justice Canada, 2018). Still, this perception leads to a reliance on police for services that draw officers away from their primary duties of public safety and protection, in particular the requirement to investigate criminal activity and apprehend those committing it. Given that between 50% and 80% of police reported occurrences are non-criminal in nature, it is apparent that police are being accessed for more issues than serious crimes, likely due to these very expectations (Canadian Association of Chiefs of Police, 2015; Conor, 2019; Vancouver Police, 2016).

Although police reported crime has decreased, the actual number of calls for service or responses has increased or remained stable (Kramp, 2014). This is attributed to increased response to non-criminal calls for service, such as for social disorder, mental health, and overall community wellbeing (Canadian Association of Chiefs of Police, 2015; Kramp, 2014; Leuprecht, 2014). While police are actively involved in criminal matters, their larger call burden is on non-criminal matters, with over 60% to 80% of all calls for service falling outside the criminal realm (Bhayani & Thompson, 2017; Canadian Association of Chiefs of Police, 2015).

This major paper examines the increasing burden on police agencies to respond to social disorder, mental health incidents, and addictions, and provides recommendations for increasing collaboration across the entire social system to address the root causes of these

afflictions. The current reliance on police to respond to these incidents is unsustainable and arguably unconstitutional due to a tendency to criminalise these behaviours, as opposed to using evidence-based methods to support those suffering from these disorders through prevention, compassion, and medical treatment. Indeed, with over 85% of police budgets allocated to salaries and benefits, leaving only 10% to 15% for operations (Conor, 2018; Leuprecht, 2014; Statistics Canada, 2018), there is little room to defund police to address these concerns. Collaboration across all sectors is required to reframe the conversation from criminality to pathways of care with a view toward the subsequent reduction in the focus on criminality to what should be seen as a health care issue.

Chapter 2: Literature Review

Police and Social Disorder

In major British Columbian (BC) cities, such as Surrey and Vancouver, police reported calls for service as the result of chargeable offences are less than 40% of the police call load (Bhayani &Thompson, 2017; Vancouver Police, 2013). This call distribution is also evident in smaller communities, particularly those with significant social issues, such as homelessness and addictions (District of Mission, 2017; Penticton, 2018). Regardless of whether the public perceives crime as increasing or decreasing, it is becoming clear that a number of drivers of crime that were typically found only in larger cities, such as homelessness, addictions, and mental health concerns, can be found in smaller communities (Walmsley & Kading, 2019). Police in smaller communities are often the only available resource to respond to concerns with this vulnerable population and have considerably less resources to draw upon than police in larger communities. For this reason, communities may be forced to turn to police to solve these issues, rather than pursue a whole of government approach, including health approaches (Livingstone, 2016).

Operating expenditures for policing in Canada exceeded $15 billion in fiscal years 2017/2018, and 2018/2019, which represented a steady rise over the previous 20 years (Conor, 2019). The rise in cost is due in part to increased salaries and operating expenditures, but also due to increased accountability and disclosure requirements (Canadian Association of Chiefs of Police, 2015; Leuprecht, 2014; Statistics Canada, 2018). Calls for service have also increased over this period. Police in Canada responded to 12.8 million calls for service in fiscal year 2017/2018, which rose to 13.5 million calls for service in fiscal year 2018/2019, at least partly

due to public demand for increased police response to mental health and addictions concerns (Conor, 2019). Concurrently, overall police strength in Canada has dropped, despite the growing level of calls for service (Department of Justice Canada, 2018). Police budgets leave little room to trim funding for non-operational responses.

Changing Nature of Police Response

Police responses in BC cities indicate an increase towards non-chargeable calls for service, although earlier reports already estimated the call load for non-chargeable incidents to be as high as 80% (Canadian Association of Chiefs of Police 2015; Malm et al., 2005; Statistics Canada, 2021b). Using the above figure of 12.8 million calls for service in fiscal year 2017/2018 as a reference, this indicates up to 10.2 million calls for service that fall outside of the criminally chargeable realm, with a significant portion of those calls consisting of mental health and social disorder related incidents (Livingstone, 2016; Vancouver Police, 2013). While it may have been necessary or desirable for police to attend many of these calls in the event the caller feared for their safety or there was an appearance of high-risk behaviour, there is cause to determine if other agencies are better suited to respond, particularly for mental health, addictions, and social issues (Centre for Addictions and Mental Health, 2013).

Police agencies throughout Canada have come to recognise the requirement to deal with people with mental health illness and addictions with respect and compassion, while, at the same time, operating within their primary mandate of community safety (Toronto Police Service, 2019; Vancouver Police Department, 2020a). Recommendations from police driven reports have centred on a common theme of increased collaboration with health authorities, including rapid assessment and treatment (Department of Justice Canada, 2018). Police

agencies appear to understand the scope of the issue and continue to advocate for an increased focus on treatment and effective interventions (Canadian Association of Chiefs of Police, 2020; Lamanna et al., 2015).

To build on their understanding of the need for collaboration, police organisations have begun to address the role of trauma in vulnerable populations, including the root causes of certain behaviours (Henry, 2019; Patterson et al., 2007). Traditional responses of arresting vulnerable individuals and introducing them to the criminal justice system fail to recognise trauma, be it due to adverse childhood experiences (ACEs), intergenerational transmission, or the result of a compendium of adverse life experiences (Jones, 2020). Research indicates that vulnerable populations, including offenders, often have a prior history of trauma dating to their childhood (Bucerius, 2020; Daubney, 2021; Maté, 2018). Bucerius et al. (2020) conducted a study in a remand centre and a provincial correctional facility in Western Canada where sentences were less than two years. They interviewed 266 male and female incarcerated individuals and determined that over 82% had been victims of crime or trauma, such as ACEs, prior to their first arrest. The study determined that incarcerated offenders almost always have a history of victimisation before criminality. Similarly, Bodkin et al. (2019) conducted a meta-analysis and determined half of the 41,000 federal prison inmates in Canada have experienced ACEs, including sexual assault, neglect, and physical abuse (Bodkin et al., 2019). Increasing awareness of ACEs in a policing context may help to inform the development of cross sectoral responses that seek to prevent poor outcomes in later life, especially with a view toward reducing criminality (Bateson et al., 2019). By effectively addressing issues early, the intent should be to prevent involvement in the criminal justice system in the first place.

Police Officers and Social Triage

Police should be the option of last resort when it comes to dealing with social issues and mental health, but often become the first response simply because there are no other agencies available or capable of dealing with an emergent situation (Canadian Mental Health Association, 2013; Centre for Addictions and Mental Health, 2019). Yet the very nature of police response can lead to the criminalisation of mental health and addictions resulting in entry into the criminal justice system by persons who would be better served by treatment and case management as opposed to incarceration (Centre for Addictions and Mental Health, 2013; Plecas et al., 2014). For instance, the opioid crisis is a public health emergency, but without adequate treatment and support, it has created significant increases in policing costs due to investigational time, response, court requirements, and offender processing when drug related incidents prompt police as opposed to health responses (Mark et al., 2019). According to the 2012 Canadian Community Health Survey (Statistics Canada, 2013), approximately 20% of police contacts involved an individual with a mental health or substance abuse disorder. This was confirmed by a recent Vancouver Police Department Study (Vancouver Police Department, 2020b) that indicated that over a two-week period, 87% of detainees reported substance use issues. Conversely, 40% of people who experienced mental health illnesses in Canada indicated that they had been arrested by the police in their lifetime, and 30% indicated that police had been involved in their pathway to care (Brink, et al., 2011).

Police also deal with a growing homeless population that has a higher rate of mental health issues than the general population (Statistics Canada, 2013). People experiencing homelessness are often the subject of complaints to police, either due to their behaviour or

societal preferences, even though the root causes of their behaviour often stem from mental health concerns, addictions, or poverty (Wilson-Bates, 2008; Wood et al., 2016). The rate of victimisation in these populations is also higher than the general population, both in terms of ongoing victimisation and previous trauma, such as ACEs (Kerman, 2020; Vancouver Police Department, 2020b). Police regularly interact with these and other marginalised individuals who have been exposed to trauma, often in early childhood, such as sexual assault, familial loss, violent crime, or poverty (Van Amerigen et al., 2008; Wood et al., 2016).

Much of what is considered criminality in communities is actually social disorder caused by poverty, mental health, and addictions (McFee & Taylor, 2014; Patterson et al., 2007; Wood et al., 2016). Over 21% of the Canadian population is estimated to have struggled with addiction in their lifetime, most commonly alcohol addiction at 18% of the 21% (Canadian Mental Health Association, 2019b; Statistics Canada, 2015). Over 10% of the Canadian population are considered to have high risk addictions, especially with regard to the ongoing opioid crisis (Canadian Mental Health Association, 2019b). ACEs are also prevalent in this cohort, with over 66% of respondents indicating at least one form of abuse prior to the age of 18 years old (Maté, 2018; Statistics Canada, 2013). These negative experiences can lead to future interaction with the criminal justice system, especially when compounded by lack of housing, community support, poverty, and access to resources (Mental Health Commission of Canada, 2020).

Most substance abuse concerns are the result of early childhood trauma or event-based trauma beyond the control of the individual (Maté, 2018). This should lead to the creation of a clear vison for addressing mental health and addiction concerns early, through treatment and

support, as opposed to reactive methods involving the police as the first level of response. Instead, up to 40% of people with mental illness indicate they have been arrested or apprehended by the police at some point in their life and 30% of those who suffer from mental health illness have had police involved in their pathway of care (Brink et al., 2011; Mental Health Commission of Canada, 2020; Livingstone, 2016). There is a significant cost to this misallocation of effective response that may be reduced through more effective collaboration amongst responsible agencies (Malm et al., 2005).

Public safety policies should rely on crime prevention policies that are evidence informed, as opposed to perception based (Welsh & Farrington, 2012). Homelessness and addictions are examples where the moral imperative to eliminate drug use may be secondary to evidence that supports the use of medical intervention instead of punitive measures (Baillargeon et al., 2009). For instance, needle distribution policies can be viewed negatively when the unsubstantiated fear of contracting disease from a needle poke outweighs the fact that there is little evidence of that ever happening, except in the case of immediate contact, and usually by emergency personnel. Despite evidence that current distribution policies prevent disease transmission and reduce health care costs (Buxton et al., 2008), the evidence alone does not seem to be enough. Even so, evidence does need to be tempered against societal values and understanding when developing policy (Welsh & Farrington, 2012). There is a need for evidentiary facts in policy making, even if the policy has as its end goal an appeasement of public opinion (Zane & Welsh, 2018).

The Social Disorder Dilemma

Increasing Acknowledgement of Social Concerns

Public opinion, stigma, and lack of understanding may result in increased calls for service dealing with social chronic behaviours, mental health, and addictions in BC communities. This highlights the need to develop a more collaborative approach to public safety, including the use of evidentiary strategies. At times, these behaviours manifest as criminal offences, such as causing a disturbance or mischief, but they tend to be on the lower end of criminality and directly attributed to social issues (Bhayani & Thompson, 2017; Mission, 2017). These concerns were already deemed health and social issues so the notion that police agencies could resolve them independently was misaligned with effective practice (BC Ministry of Mental Health and Addictions, 2019).

Research indicates that the cost to society in terms of addictions and ineffective mental health strategies is immense (Canadian Centre on Substance Abuse and Addiction, 2018; Leuprecht, 2014). For instance, the cost to society of substance abuse in 2014 was estimated at $38.4 billion (Canadian Centre on Substance Abuse and Addiction, 2018). The cost of mental health treatment in Canada is estimated at $51 billion per year, but this is still insufficient to meet the need (Centre for Addictions and Mental Health, 2019).

In April 2016, the BC provincial health officer declared a public health emergency under the BC Public Health Act in response to a growing number of opioid-based overdose deaths since the beginning of that year (Henry, 2019). The public health emergency allowed for the increased disbursement of funds to assist in preventing overdose deaths, with a particular focus on harm reduction measures, pathways to treatment and care, and engagement with persons

with lived experience (BC Ministry of Mental Health and Addictions, 2020). While these approaches have been somewhat effective, especially in BC (Hyshka et al., 2017), the crisis continues in BC and across Canada. Between January 2016 and June 2020, 17,602 people died in Canada from apparent opioid toxicity deaths. BC is the de-facto epicentre of the crisis with over 6,733 of those deaths occurring in the province between 2016 and the end of 2020 (BC Coroner Service, 2021; Government of Canada, 2020a).

The stigma associated with overdose deaths tends to focus on street level vulnerable populations; however, statistics indicate the problem is much broader (BC Coroner Service, 2021). Socio-economic factors do play a major role in the death rate, especially with regard to unemployment and poverty (Statistics Canada, 2021c). However, in BC, one-third of opioid overdoses occurred in employed populations, primarily in the construction industry, although 65% of those individuals indicated they had experienced unemployment in the five years prior to their first overdose (Statistics Canada, 2021c). In total, 41% of those who experienced an overdose were unemployed, but those were not necessarily street entrenched. Further countering the notion that overdoses are associated to criminality is the fact that 60% of those who have overdosed in the previous two years had no police contact in that timeframe (Statistics Canada, 2021c).

Table 1 illustrates the alarming rate of drug toxicity deaths in BC over the past ten years. The data indicate that the majority of deaths occurred in higher population areas; however, factoring in population densities, it becomes apparent that the opioid crisis is not limited to major cities and is in fact a provincial issue.

Table 1: Illicit Drug Toxicity Deaths by Health Authority. *(BC Coroner Service, Feb. 11, 2021)*

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Interior	37	38	31	54	47	64	168	246	233	138	281
Fraser	86	115	104	106	126	208	334	492	522	328	568
Vancouver	52	81	72	95	120	160	276	448	450	285	472
Island	23	45	45	60	55	72	161	241	243	166	263
Northern	13	16	18	19	21	25	52	66	101	67	132
BC	**211**	**295**	**207**	**334**	**369**	**529**	**991**	**1493**	**1549**	**984**	**1716**

The assumption that the majority of opioid related harms are found in street entrenched populations is also refuted by the data presented in Table 2. Considering that overdoses that occur outside account for only 14.3% of the total, it is evident that the problem extends beyond the street entrenched population, albeit potentially within populations that may experience economic instability.

Table 2: Illicit Drug Toxicity Deaths by Place of Injury 2017-2020. *(BC Coroner Service, Feb. 11, 2021)*

	2017	2018	2019	2020
Inside				
Private Residence	898	923	566	959
Other Residence	366	372	259	450
Correctional/Police Cell	3 (0.2%)	6 (0.4%)	4 (0.4%)	5 (0.3%)
Medical Facility	1 (0.1%)	5 (0.3%)	5 (0.58%)	6 (0.4%)
Occupational Site	10 (0.7%)	6 (0.4%)	6 (0.6%)	5 (0.3%)
Public Building				
Public Washroom	26 (1.7%)	23 (1.5%)	11 (1.1%)	6 (0.4%)
Other Area of Building	7 (0.5%)	11 (0.7%)	7 (0.7%)	13 (0.8%)
Outside	177	194	118	245
Unknown	5 (0.3%)	9 (0.6%)	8 (0.8%)	27 (1.6%)
Total	**1493**	**1549**	**984**	**1716**

The majority of deaths occurred in residential settings, indicating a problem that goes well beyond street entrenched vulnerable populations into vulnerability as a function of broader factors, such as unemployment, trauma, injury, and poverty. As with the overall statistics, Table 3 indicates the death rate due to drug toxicity is not isolated to major

population centres, with the majority of deaths occurring in residential settings, regardless of Health Authority jurisdiction.

Table 3: Illicit Drug Toxicity Deaths by Place of Injury and Health Authority 2017-2020. *(BC Coroner Service, 2021)*

	Interior	Fraser	Vancouver	Vancouver	Northern
Inside					
Private Residence	593	1365	591	552	245
Other Residence	161	221	789	209	67 (18.3%)
Other Inside	32 (3.6%)	62 (3.3%)	41 (2.5%)	19 (2.1%)	12 (3.3%)
Outside	106	245	219	123	41 (11.2%)
Unknown	6 (0.7%)	17 (0.9%)	15 (0.9%)	10 (1.1%)	1 (0.3%)
Total	**898**	**1910**	**1655**	**913**	**366**

Why Police Became the Front-line

The data in Tables 1 to 3 indicate that drug toxicity deaths extend well beyond traditionally recognised vulnerable populations. The recognition of past trauma as a primary factor in addictions, mental health illness, and homelessness is important when discussing policy alternatives (BC Justice Summit, 2015; Maté, 2009). Table 4 indicates illicit drugs are overwhelmingly responsible for drug toxicity deaths, which further emphasises the need to address alternatives to a criminal justice only approach to substance abuse issues. Criminalising drug addiction has not had the effect of reducing drug toxicity deaths. The data in previous tables suggests the rate of overdose deaths has increased since the public health emergency was declared in BC, despite current enforcement approaches.

Table 4: Top Drugs involved Among Illicit Drug Toxicity Deaths. *(BC Coroner Service, 2021)*

Drug Detected	
Illicit fentanyl and analogues	86.8 %
Cocaine	49.4 %
Methamphetamine/amphetamine	35.2 %
Other opioids	29.8 %
Ethyl alcohol	28.1 %
Benzodiazepines	4.3 %
Other stimulants	2.7 %

Note: Percentage does not total 100, due to multiple drugs detected in some of the deaths

The call for alternatives was borne out in three successive BC Justice Summits from 2015 to 2017 inclusive. Justice Summits are mandated by the BC Justice Reform and Accountability Act (2013) and are held at least once per year. The summits include a cross representation of participants from all aspects of the justice system, including the Solicitor and Attorneys General of British Columbia, chief justices, judges, legal professionals, police and law enforcement leaders, academics, and advocacy groups to encourage cooperation and performance improvement. What is telling in the three years of reports on proceedings is the recognition to do better across the sector and other governmental sectors to improve the understanding of the health impacts affecting vulnerable populations, including those involved in criminality. The 2015 BC Justice Summit identified the need to move forward with trauma informed practices, with further recommendations to coordinate information sharing between family justice, criminal justice, and child protection.

The 2016 and 2017 BC Justice Summits went further into defining the intersectionality between mental health, addictions, and the criminal justice system (BC Justice Summit, 2017). Both summits identified the need for coordination between the criminal justice system and the

health and social support sectors, including early intervention, continuity of care, and a better understanding of the complex nature of high-risk individuals found in vulnerable populations. The summits further recommended the creation of a framework for cross sectoral collaboration, continuity of care, coordinated crisis response protocols, reduction of stigmatisation, and assistance with navigating a complex social support system (BC Justice Summit, 2017). Although there has been some success in implementing recommendations from the 2017 summit, effective responses have been slow to materialise, particularly at the legislative level (BC Virtual Justice Summit, 2020).

What is striking with respect to the BC Justice Summit reports is the coordinated understanding across the justice system for the need to improve access to health and support approaches, as opposed to criminal justice system approaches for vulnerable populations. This was borne out once again in the 2020 summit that focused on alternatives to incarceration and a drawdown of the use of the justice system to address societal issues as a result of addiction, mental health, and homelessness (BC Virtual Justice Summit, 2020). In other words, the wide range of legal and justice professionals agreed that the justice system was the wrong approach to these complex social issues, with little chance of effective change without cross sectoral collaboration (BC Virtual Justice Summit, 2020).

There is a tendency to associate violence to mental health and substance abuse, particularly controlled substances (Canadian Mental Health Association, 2013). Unfortunately, vulnerable populations, such as street entrenched people, youth, and marginalised individuals have a higher representation of mental health and substance abuse issues, in some cases, compounded by dual diagnoses (Bucerius et al., 2021; Livingstone, 2016; Statistics Canada,

2012). This creates a tendency to criminalise these populations, which has the effect of pulling police into these issues as the solution, rather than as a supporting agency to more effective strategies delivered by others. Mental illness is in and of itself not predictive of violent tendencies; however, persons with mental health issues may become violent (Boyd & Kerr, 2016; Canadian Mental Health Association, 2013). This violence is more a function of community factors, such as a lack of treatment options, lack of housing, and increased exposure to violence, rather than an inherent tendency towards violence on the part of the individual (Centre for Addiction and Mental Health, 2013; Canadian Mental Health Association, 2013; Vancouver Police Department 2020a).

In part, arrests of these individuals are due to police officers who do not recognise the mental health issues involved or have no other option due to lack of treatment availability (Canadian Mental Health Association, 2003: Coleman & Cotton, 2010). Once again, this phenomenon of police as the first line of response to persons in mental health crisis or those who suffer from substance abuse disorders is compounded by an increased prevalence of these interactions (Livingstone, 2016). Livingston's conclusions are similar to the experiences outlined in the Vancouver Police Department's 2013 report and those of the Toronto Police Service (2019). He points out that numerous public inquiries and inquests have served to raise awareness of the issue of increasing police response to mental health incidents. Livingston's conclusion is clear in that many police interactions may be unnecessary and avoidable with more effective medicalised interventions (Livingston, 2016; Canadian Mental Health Association, 2003).

The notion that police deal with people who are in a state of vulnerability, as opposed to being intent on committing crime, is echoed across the country (Department of Justice Canada, 2018; Kramp, 2014). With such a high percentage of non-criminal calls, it is troubling, but not unexpected, that police become triage agents for what should be considered health and social issues (Canadian Mental Health Association, 2019a; Maté, 2018).

The Role of Police in Modern Society

In BC and in most areas of Canada, policing is conducted at three separate levels: federal, provincial, and municipal (Conor, 2019). Although police resourcing at the municipal level showed an increase over the past ten years, the same cannot be said of the provincial and federal components (Conor, 2019). With the exception of communities with their own police service, in particular larger municipalities, much of the policing in BC is conducted by the Royal Canadian Mounted Police (RCMP). This is done through the Provincial Policing Service Agreement (PPSA) for communities and areas under 5,000 population, or the Municipal Policing Service Agreement (MPSA) for communities over 5,000 (BC PSSG, 2020). In Ontario and Quebec, provincial police agencies operate in a similar manner for communities without their own municipal police department. Independent police departments are governed by police boards that set priorities and general strategies, leaving operations to the police service (BC Ministry of Public Safety and Solicitor General, 2020). Similarly, RCMP detachments bound by the PPSA or MPSA rely on performance planning to set priorities with their local, regional, and provincial governments (BC Ministry of Public Safety and Solicitor General, 2020). Regardless of the community or level of service, policing priorities are set by government, either directly or through a police board in collaboration with the respective police service (BC Laws, 1998).

Despite the constitutional principle that police are independent of government once priorities are set, police are often called to address the complex social issues of addiction, mental health, and homelessness (Roach, 2017). However, their mandates as set by governments are generally geared towards public safety and protection, which currently includes issues of social disorder that contribute to negative perceptions of these vulnerable populations. Yet the responsibility for social and health issues should instead lie with the respective governmental level themselves, as opposed to their law enforcement agencies (Roach, 2018).

Overall, crime rates in Canada are trending down over the past ten years, particularly with respect to violent crime (Statistics Canada, 2021b). Even though there are annual fluctuations, the overall Crime Severity Index (CSI) indicated that police reported crime in 2019 was 9% lower than in 2009 but has been trending up for the past five years. The CSI measures the volume and severity of police reported crime, excluding traffic, that, in 2019, totalled 2.2 million incidents (Statistics Canada, 2021b). The violent CSI was down 4% over the previous ten years and the non-violent CSI was down 11% compared to 2009 (Statistics Canada, 2021b). This brings forward an interesting question. If overall police reported crime is down, why are police costs going up? The short answer is found in the increasing complexity of policing and the criminal justice system as a whole that go well beyond actual calls for service (BC Virtual Justice Summit, 2020; Canadian Association of Chiefs of Police, 2015; Department of Justice Canada, 2018; Leuprecht, 2014; Malm, 2005).

Regardless of the nature of the work being done, the time required to document investigations and conduct proactive policing is not measured in crime statistics alone (Kramp, 2014). Even a minor investigation will take a significant portion of a police officer's time when

factoring in travel time and increasing investigational steps (Canadian Association of Chiefs of Police, 2015; Malm et al., 2005). Add to this the requirement for increased training, technical competency on evolving equipment, and community expectations with respect to visibility and it becomes clear that police are experiencing increased demands on their time. This is not because crime is necessarily on the rise but calls for service and constraints on police officer time continue to rise, even if these calls are not criminal in nature (Department of Justice Canada, 2018; Kramp, 2014; Leuprecht, 2014).

Despite rising costs, police are stretched in different directions that can pull them away from their primary mandate of public safety (Department of Justice Canada, 2018; Huey et al., 2016). A significant portion of offenders are charged for relatively minor offences that stem from a survival response due to addictions or mental health concerns (Canadian Association of Chiefs of Police, 2020; Plecas et al., 2014; Vancouver Police, 2020b). It is apparent that an inordinate effort is going into using the police and courts as the social triage element (Canadian Association of Chiefs of Police, 2020; Huey et al., 2016). To consider police in particular as the triage for mental health and addictions is a startling indictment of society's ability to treat its most vulnerable. It is difficult to determine the overall cost of the justice system across Canada due to different provincial and territorial systems; however, estimates indicate that between 2014 and 2017, annual policing costs were approximately $14.7 billion, court services and prosecutions cost $1.8 billion, corrections costs were $4.7 billion, and legal aid expenditures were over $800 million (Moore et al., 2018). Considering that a significant portion of these costs are directed at persons who require treatment as opposed to incarceration, it is apparent

that alternatives to the expensive realities of courts and incarceration are needed (Department of Justice, 2018).

The financial costs listed above are exacerbated by the human toll. Loss in dignity, productivity, impaired job performance, and long-term disability are less tangible measures than police reported crime statistics but equally grave (Henry, 2019). Many of the people involved in the justice system are also involved in the health and social systems. Costs across all of these sectors could diminish if the criminal justice system was transformed to focus on wellbeing and reintegration as opposed to punishment (Poleg & Sandlie, 2011; Maté, 2018).

Criminalisation of Addictions, Mental Health, and Homelessness

Crime reduction efforts and the approach to street level vulnerable populations are the purview of individual municipalities, and lack the full coordinated approach across agencies, in particular with respect to mental health and addictions (Maté, 2018). In the report of the Blue-Ribbon Panel for Crime Reduction, Plecas (2014) indicated that the majority of crime is committed by a very small portion of the population. The report further indicated that by focusing on prolific offenders, crime rates could be substantially reduced. Police agencies are particularly well suited to this type of targeting; however, they are often hampered in effective enforcement strategies by a need to respond to social issues, such as substance abuse and mental health that should be outside their primary mandate as these are health issues (Henry, 2019). Police should spend more time focussing on prolific offenders; however, over 60% of police reported occurrences are in response to non-chargeable occurrences. Many of these deal with vulnerable populations and social disorder (Canadian Association of Chiefs of Police, 2015; Coleman & Cotton, 2010; Department of Justice Canada, 2018; Roy et al, 2020). The report by

Plecas (2014) clearly endorsed inter-agency collaboration though initiatives, such as treatment versus incarceration, for those with mental health and addictions issues, an increase in accessibility to supports, and a whole of government approach to social issues.

Plecas (2014) recommended a shift in policing priorities toward a more complete focus on crime reduction, whereby the most prolific offenders are targeted by the police. The report further recommended alternatives to incarceration consistent with the community safety and wellbeing (CSWB) approach currently underway in some communities in BC (BC Ministry of Public Safety and Solicitor General, 2018). CSWB posits a whole of government approach as the most effective way to deal with chronic social issues ranging from mental health and homelessness to effective crime reduction techniques, as recommended by Plecas (2014). This perspective was amplified in the *Economics of Policing* report from the Parliamentary Standing Committee on Public Safety and National Security that included as one of its recommendations the need to increase collaboration across all governmental sectors with a view towards prevention before justice system involvement (Kramp, 2014).

Vulnerable populations, such as street entrenched people, youth, and marginalised individuals, can become criminalised in a society that demonstrates a desire to minimise visible deviant behaviours in the name of crime reduction or the perception thereof (Centre for Addiction and Mental Health, October 2013, Maté, 2009, Morrisey et al., 2007; Roy et al, 2020). The lack of effective responses and the criminalisation of social issues may result in expectations from police and enforcement agencies that are actually outside of the *Charter of Rights and Freedoms* and contrary to the goal of overall CSWB (Department of Justice Canada, 2018; Erickson et al., 1997; McFee & Taylor, 2014). These expectations lead to a culture of

forced legal action against a population that should be receiving treatment (Huey et al., 2016; Vancouver Police, 2013; Wilson-Bates, 2008). By not receiving treatment and being seen as deviant, the problems faced by vulnerable populations are compounded as police interaction forces those needing help further into the shadows (Lamanna et al., 2015). Furthermore, there is little evidence to support the notion that a criminal justice approach has had a significant effect on reducing addictions, overdose deaths, or social disorder in Canadian communities (Canadian Association of Chiefs of Police, 2020; Henry, 2019). Canadian drug policy continues to be caught between a tough on crime enforcement perspective and the need to address complex addiction illnesses though a public health approach (Erickson et al., 1997; Fischer et al., 2016).

De-Institutionalisation, Stigmatisation, and Trauma

Much of the current police response to mental health and addictions stems from the de-institutionalisation of people suffering from mental health illnesses (Bond et al., 2001). This resulted from the policy decision to close psychiatric facilities in favour of community-based treatments (Brodwin, 2011). This decision was due to economic, pharmacological, legal, and humanitarian concerns. The process began as early as the 1950s in the United States with a similar timeframe in Canada (Bond et al., 2001, van der Kolk, 2014). In BC, the most notable instance was the closure of Riverview Hospital that began by downsizing in the 1980s to its final shut down in 2012. At issue was the reality that community-based resources were insufficient to treat the growing demand of mental health occurrences, especially when co-diagnosed with addictions (Livingstone, 2016; Markowitz, 2006). An increased reliance on pharmacological care reinforced the notion that community treatment could fill the void, even though evidence

would suggest previous patients did not have sufficient access to continuous care that exposed them to increased criminal justice responses due to their untreated behaviours (Baillargeon et al., 2009; Livingstone, 2016; van der Kolk, 2014).

The behaviours of persons suffering from mental health illnesses can be manifested as deviant to societal norms, even though the visible manifestation is the result of inadequate treatment (Kramp, 2014). This generates a level of stigma against these populations, especially when concurrent to visible substance abuse (Crapanzano, 2014). Despite evidence that much of the vulnerable population in BC is incapable of sustained care without support, this cohort is often vilified in public discourse and in the media (Government of Canada, 2020; Walmsley & Kading, 2019). The perception that the homeless population contributes significantly to crime is not established in crime reports. Although some prolific or chronic offenders may be homeless, there is little evidence to support the notion that homelessness itself directly equates to criminality. Vulnerable populations are stigmatised by a justice system that is quick to respond to the criminalisation of addictions and mental health behaviours due to a lack of cross sectoral response (Department of Justice Canada, 2018).

Research indicates that the cost, both financial and human, of current social issues, such as overdose deaths, is immense in terms of response and societal effects (Henry, 2019). Over 6,000 British Columbians have died from drug toxicity deaths since the BC opioid overdose public health emergency was declared in 2016 (BC Coroner Service, 2021), yet progress on harm reduction efforts, decriminalisation, and the development of treatment remains slow (Henry, 2019).

The Nexus to Homelessness

The correlation between addictions, mental health, and homelessness is well established (Bonkiewicz et al., 2014; Corrigan et al., 2009; Kramp, 2014; Lamanna et al., 2015). In a 2018 homeless count sponsored by BC Housing, 58% of respondents indicated they had one or more health conditions that created barriers to housing with the majority of those conditions listed as mental health and addictions related (BC Housing, 2018). While drug possession is a criminal offence, the actual use is established as a health issue (Henry, 2019) that often includes concurrent disorders, such as mental health concerns (Bucerius et al., 2021). Although it can be argued that many criminals are suffering from mental health and addictions issues, providing stabilisation and housing, as opposed to incarceration, should produce better long-term outcomes for reducing crime, especially when the cost of medical support, corrections, and law enforcement exceeds the cost of supplying supports and infrastructure, such as supportive housing (BC Virtual Justice Summit, 2020; Patterson et al., 2007). Regardless of the causes of homelessness, it is a cause for concern in many communities. Frustrated with the perceived inability to solve the problem and facing community backlash, several communities have opted for increased enforcement, even though the evidence exists that housing is a better solution, both morally and economically (Patterson et al., 2007; Penticton, 2018). Further, smaller communities in BC are now facing similar issues to large cities and often turn to enforcement through bylaws to move homeless and vulnerable people to other areas of the community (Walmsley & Kading, 2019). This does nothing to address the root causes of homelessness and further victimises an already marginalised population (Penticton, 2019; Maple Ridge, November 2019).

Housing concerns in BC are not new. In the 1980s, the discussion around homelessness in BC usually focused on the Downtown East Side of Vancouver (BC Housing, 2019a). Since then, the street entrenched population has continued to grow, as have concerns over open drug use and increasing perceptions of lawlessness (Roy et al., 2020). The Housing First model endorsed across Canada is geared to provide independent living for any category of homeless or low-income individuals with an intent to provide rapid housing options. These options range from drop-in centres and shelters to permanent living options (Canham et al., 2019). The ultimate goal is to stabilise individuals either for continuing treatment or re-integration to end the cycle of homelessness. The BC Housing Action Plan (2019b) is largely based on the tenets of Housing First, which was an ideology first used in the United States and expanded into much of Canadian housing philosophy (Turner, 2019). Essentially, Housing First implies that those experiencing homelessness cannot progress towards treatment and independence without first being provided with a stabilised environment. As such, focussing on the rapid movement of homeless people through various levels of housing is deemed the most cost-effective manner to reduce homelessness in any given community (Turner, 2019).

Health Approaches to Social Disorder: What is Working?

Although there is a recognition of the need for increased support for those suffering from addictions and mental health, police agencies have been dealing with the issue for some time (Canadian Mental Health Association, 2003). Faced with an increasing demand, police agencies in Canada have developed strategies to support vulnerable populations, often in collaboration with advocacy groups and health agencies (Fahim et al., 2016; Koziarski et al., 2021; LeFebvre et al., 2018; Toronto Police Service, 2019, Vancouver Police Department, 2016,

2020b). Although these strategies may be initially developed by police, the most effective manner is though collaboration and a whole of government approach (McFee & Taylor, 2014). A significant component of the Toronto and Vancouver approach is to break down the barriers of stigma and focus on accountability and learning. The need for continuous learning with respect to mental health and addiction was emphasised by Coleman and Cotton (2010) in their report to the Mental Health Commission of Canada. They recognised the increasing number of police interactions with persons with mental illness, and accurately assessed the need for police to be responsive to vulnerable populations, and to be prepared for these interactions through the whole range of police calls for service. Although Coleman and Cotton (2010) advocated for a specific training model, their assertion was that police can best deal with mental health interactions through client centred policies, as opposed to enforcement options. Their report was published ten years ago, and police have continued to develop training to address this critical area, such as co-responder models and outreach (Vancouver Police 2020b). Police still need to be prepared to use force to prevent serious injury to themselves or their clients; however, the need to quickly resolve a mental health incident should be secondary to the wellness of the individual, especially when there is no criminality apparent (Wood et al., 2016).

Although it is well established that a significant proportion of vulnerable populations engage in social disorder or low level criminality have been exposed to ACEs and other forms of trauma, police often remain the first responders to initial crisis (Elklit, 2002; Huey et al., 2016). This is attributed, in part, to the lack of available appropriate resources, such as mental health professionals and hospital facilities (Huey et al., 2016; Leuprecht, 2014). Although there are increased demands for police training with respect to de-escalation and interaction with

vulnerable populations, their primary duties toward public safety can be at odds with providing effective care and connection to treatment (Huey et al., 2016). Calls for service to the police often fill the gap to deal with crisis situations when it would be more appropriate to allocate prevention and treatment resources to prevent the crisis in the first place (Kramp, 2014; Plecas et al., 2014; Wood et al., 2016).

Most mental health related incidents are resolved informally; however, police simply cannot walk away from someone who is a danger to themselves or others (Bonkiewicz et al., 2014). Without dedicated, on-shift mental health professionals, police are forced to either place the person in custody or bring them to a medical facility, taking them away from their primary duties as they wait for assistance. Crisis intervention teams, such as Assertive Community Treatment (Lamanna et al., 2015), and police and mental health partnerships, such as Surrey RCMP's Car 67 program (Fraser Health, 2020), are effective ways to increase immediate assessment and care, including rapid referral to appropriate treatment. Crisis Intervention Teams (CIT) are an evidence-based policing practice that, if implemented properly with trained police officers and medical professionals, are able to reduce negative interactions with those suffering from mental illness and increase pathways to care (Fahim et al., 2016; Watson & Fulambarker, 2012; Watson et al., 2017). They are preferable to police only interactions with those in mental health crisis, particularly those who are not in a violent state (Bonkiewicz et al., 2014); however, they are reactive to incidents, as opposed to being outreach centric.

Vulnerable Community Outreach

The concept of Assertive Community Treatment (ACT) programs began over 40 years ago in Madison, Wisconsin and has since spread throughout countries in North America, Europe, and Australia (ACT-BC, 2021; Bond et al., 2001). There is a significant body of evidence to support the effectiveness of ACT in reaching vulnerable populations to meet their mandates of providing community mental health treatment (Aubry et al., 2016; ACT-BC, 2021; Bond et al., 2001; Daubney et al., 2021; Lefebvre et al., 2018). The primary outcomes of ACT are reductions in psychiatric hospitalization and mental health occurrences, with a commensurate increase in vulnerable population stabilisation through housing and direct access to health services (Bond et al., 2001; Phillips et al., 2001). These outcomes are also measured by decreased police calls for service and an overall reduction in continuing treatment costs (Lehman et al., 1998).

From an outreach perspective, ACT teams create cross sectoral collaboration, including health professionals, social services, and other service providers that are focussed on the stabilisation of vulnerable communities (Bond et al., 2001). People with complex mental illness and addictions are particularly well served by the in-community approach of ACT, reducing their exposure to the negative outcomes of a street-entrenched lifestyle through a wraparound approach (Aubry et al., 2016; ACT-BC, 2021; Vancouver Police Department, 2020a; Watson et al., 2017). The programs provide ongoing and continuous services, such as medication administration and monitoring, assistance with housing, and counselling (Bond et al., 2001; Norris, 2020). The services provided by ACT often extend to 24-hour operations to meet the specific needs of clients that include multiple contacts per week, access to food and shelter, access to medical care, and rehabilitation (ACT-BC, 2021). Perhaps the greatest benefit is the

ongoing care that allows clients to build on successes with the support of a safety net of consistent service providers. ACT units typically manage a small caseload of the most at-risk individuals to provide ongoing support and eventual stabilisation to housing and supports (Bond et al., 2001).

With over 20 ACT programs active in BC, the benefits are apparent to many communities (ACT-BC, 2021; Pope & Harris, 2014). The success of the program with respect to collaboration with police agencies is demonstrated by three collaborative programs involving police, among others. The Vancouver Police Department fielded the Assertive Outreach Team in March 2014 based on ACT principles to stabilise high risk individuals and transition them to continuing care. The team emphasises the need for collaboration between police, psychiatric professionals, and case workers to support clients suffering from complex and often concurrent disorders. The team assists between 20 to 40 clients at any given time and helps them navigate the social support structures in the city (Vancouver Police Department, 2021a). Concurrent with their outreach work, one member of the police department works closely with the five ACT programs in the city, serving 289 clients (Vancouver Police Department, 2021b). Police are able to locate individuals, assist in connecting them to supports, and provide support to ACT units in the field (Vancouver Police Department, 2020a). The result of the VPD approach was a significant reduction in crime among the active clients. This included a 53% decrease in the number of negative police contacts, a 49% decrease in clients committing violent crime, a 62% decrease in mental health apprehensions, and a 49% decrease in criminal justice system involvement in 2020. From a medical perspective, the results were similar with a 61% decrease in emergency department visits and a 74% decrease in mental health bed days among the

identified clients, over a one-year period ending August 2020 (Vancouver Police Department, 2021b).

Similar to the Vancouver Police Department approach, the Surrey RCMP developed the Surrey Outreach Team in 2017 that expanded to the Police Mental Health Outreach Team in 2019 (Surrey RCMP, 2021). The genesis of the team was a growing tent city and social concerns in the downtown core of the city. The team consists of police, bylaw officers, mental health professionals, housing contacts, community partners, and social services similar to the Vancouver programs. The aim was the same; to actively reach out to vulnerable populations to provide wraparound support (Surrey RCMP, 2021). In 2018, the team produced a collaborative solution to the homelessness issues in the city core by obtaining temporary housing for almost all of the immediate street entrenched population, while concurrently providing outreach and treatment options (Collins, 2019). The team continues to provide outreach to vulnerable people in Surrey, through a continuing partnership with Fraser Health and BC Housing (Surrey RCMP, 2021). What is encouraging about these police connected programs is the recognition of the need for cross sectoral collaboration to provide a suite of solutions to complex social issues, as opposed to one size fits all.

Although research indicates that police in Canada are increasingly responding to calls associated to mental health illnesses and social disorder (BC RCMP, 2021; Statistics Canada, 2015), ACT teams often operate without the assistance of police. The police can assist the ACT team in locating individuals and providing protection if required. Police databases also provide valuable information on individual challenges in the community that can be shared with proper privacy impact assessments. Given current pressures to examine police budgets, there is scope

to examine civilian-led, medical approaches that do not require direct police intervention. Police collaboration with ACT and outreach teams demonstrate positive results with respect to community wellbeing; however, in some circumstances, police presence at calls for service dealing with vulnerable populations may have an intimidating or coercive effect (Norris, 2020). This leads to the potential for using dedicated, non-police resources, such as the Support Team Assisted Response (STAR) program in Denver, Colorado (Sachs, 2021). The team is similar to the co-responder model used by the Vancouver Police Department (Car 87) and the Surrey RCMP (Car 67) that pair a police officer with a psychiatric professional. In the case of STAR, the police officer is replaced by a paramedic. In over 740 incidents, no arrests were required. The direct focus of the STAR concept was to remove the criminal justice response to mental health concerns in the community and was fully endorsed by the city's Chief of Police who is seeking to expand the program (Sachs, 2021).

Although it is deemed a civilian-led approach, the team often works collaboratively with police, who are usually in a support role, even to the point of calling the STAR team when they realised their approach would be more suitable. Most of the calls dealt with by the STAR program were focussed on social or clearly mental health related calls which were deemed low risk to the responders. The net effect of the program was a reduction in police calls for service and an increase in service to the affected vulnerable population. This type of approach, which does not seek to replace existing systems, such as ACT, indicates a positive step forward to full community response to wellbeing (Sachs, 2021).

It is important to consider; however, that the removal of police from these types of efforts is not always practical. For instance, in Vancouver, police reported that they responded

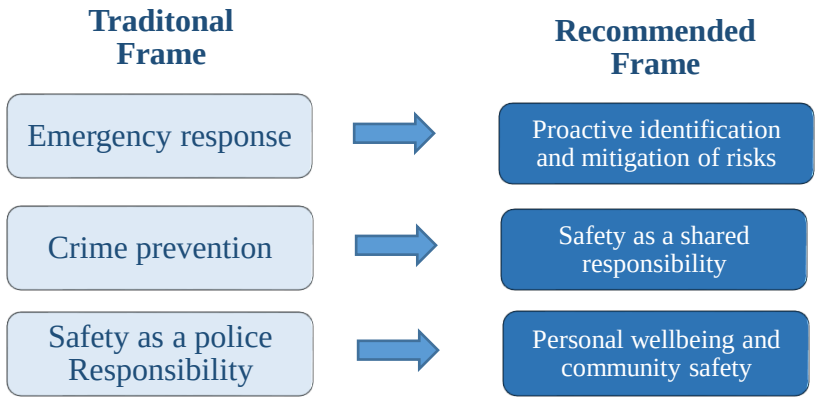
to 13,592 calls for service in 2019 where mental health was a contributing factor, with 84% of these calls requiring police attendance. One-quarter of the calls were received from health care professionals who needed police assistance (Vancouver Police Department, 2020b). Simply removing police from the response continuum may not be as effective or practical as encouraging cross sectoral cooperation and collaboration towards community wellbeing.

Cross Sectoral Collaboration

An example of effective cross sectoral collaboration at the local level was found in the Situation Table model that gained traction in Prince Albert Saskatchewan (McFee & Taylor, 2014). Faced with an increasing crime rate, elevated CSI rating, and an increase in calls for service, police identified the need to create an alternative to the traditional reactive response to the social issues in Prince Albert. Many of the police calls for service were based on social issues, such as addictions and mental health, to a point that their volume exceeded traditional criminal code caseloads (McFee & Taylor, 2014). Factors such as a high youth mortality rate, higher than average infectious disease rates associated to drug use, poor education rates, inadequate housing, and changing demographics clearly identified a problem well out of the scope of the police to deal with. Through discussion and engagement, partners in law enforcement, social services, health, community support, and housing came together to create what is viewed as the first situation table or “Hub” in Canada (Kramp, 2044; Nilson, 2016). Despite police being actors in many of these issues, a whole of community approach was identified to produce meaningful outcomes towards CSWB (Kramp, 2014; McPhee & Taylor, 2014).

Police are not particularly well suited to address these societal issues on their own, even if they may be the first response (McPhee & Taylor, 2014). Inter-agency cooperation and collaboration are equally important to crime reduction as direct police response. This is especially relevant to police agencies that are viewed as responsible for most aspects of crime reduction and prevention, since these initiatives are offender based (Russell & Taylor, 2014). While police certainly have a significant role in this regard, Russell and Taylor (2014) suggested that prevention and collaboration as a means to address root causes of crime will have better outcomes compared to enforcement. As outlined in Figure 1, they suggested a different framework that focused on collaboration as opposed to traditional responses (Russell & Taylor, 2014). While traditional responses will still be required in certain aspects of public safety planning, reframing the traditional methods through a lens of CSWB can change the approach to one shared responsibility, engagement, and community mobilisation.

Figure 1: Gaining momentum: multi-sector CSWB in Ontario,
Russell and Taylor (2015).



Following the implementation of the Saskatchewan model, Ontario went a step further through the establishment of guiding legislation (Ontario Ministry of Community Safety and Correctional Services, 2018). The guiding legislation provided the opportunity to expand on the

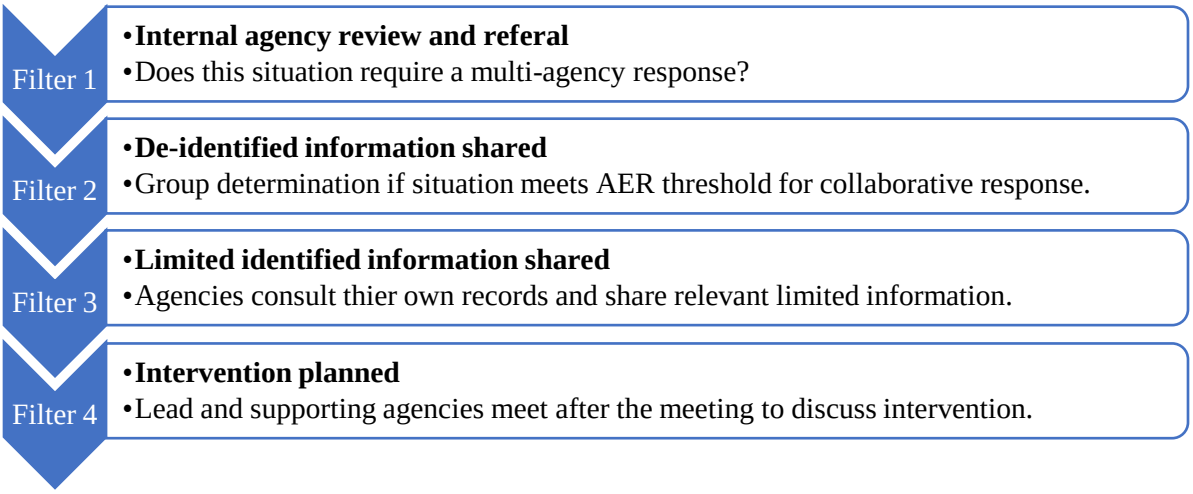
hub model already endorsed by Saskatchewan to the implementation of a CSWB Framework (Ontario Ministry of Community Safety and Correctional Services, 2018). As a result, situation tables, or hubs, were developed across the province. Moving vulnerable persons towards wellness is a key component of the recommendations for health-centred approaches, such as decriminalisation (Henry, 2029). To this end, preventing involvement in the criminal justice system can be supported through collaborative efforts, such as community mobilisation. Failing prevention, cross-sectoral collaboration, in terms of restorative justice and reintegration, will have better outcomes than a rush towards incarceration (Plecas et al, 2014; Ploeg & Sandie, 2011; Vancouver Police, 2020).

The establishment of Situation Tables often falls to police agencies to implement. This was certainly the case in Prince Albert (McPhee & Taylor, 2014) and was consistent in other BC communities, such as Mission, Penticton, Kelowna, and Williams Lake (Mission, 2017; Penticton, 2018). This is not necessarily counterproductive to CSWB implementation; it simply requires a commitment on behalf of the police to engage fully with their community, which is a commitment that should be at the core of any service delivery model. Although police may initiate the discussion, it is important that they are not seen to take charge or to have solely crime fighting motives at the table to ensure collaboration of all table participants (Bhayani & Thompson, 2017).

At the core of the Situation Table model is the need to intervene quickly. When a situation is identified, participants at the table work quickly to assist those who are at imminent risk of harm, victimisation, or criminality (Ontario MCSCS, 2017; McFee & Taylor, 2014; Penticton 2018). The Situation Table model uses a four-filter approach to assess acutely

elevated risk to rapidly identify risk factors and to determine the most appropriate lead and support agencies. As depicted in Figure 2, the four-filter approach also protects the confidentiality of partner databases and information, as well as the identity of the person until such as time as it is necessary to reveal the name of the individual or group (McFee & Taylor, 2014).

Figure 2: Four filter approach to CSWB.
BC Office of Crime Reduction and Gang Outreach (2019).



Decriminalisation

The war on drugs in Canada has been active for decades as a central policy theme with little overall effect (Hathaway & Tousaw, 2008). It can be argued that rates of addiction and negative outcomes have become worse since the implementation of current policy (Henry, 2019; Maté, 2018). The moral panic of drug use may have convinced a wary population that despite the harm of drugs and the strength of trauma, addictions are a matter of choice, particularly with respect to illicit drugs (MacKay, 2018). Increased spending on dated justice system approaches stemming from this attitude, such as short-term incarceration for minor

survival based criminal and drug offences, has had little success in changing criminal or social behaviours (Hayle, 2019; Manitoba Ministry of Justice, 2018; Ploeg & Sandlie, 2011).

The failure to address the root causes of criminality and social disorder has led, in part, to a failing war on drugs indicating the need for a cross sectoral approach to lower the incidents of criminality associated to addictions and mental health (Canadian Association of Chiefs of Police, 2020; Jesseman & Payer, 2018). Although decriminalisation should have the effect of reducing survival-based criminality while increasing community wellbeing, there is a need for caution before rushing headlong into this approach without the necessary resources in place (Jesseman, & Payer, 2018; Moore et al., 2018). The Portugal experience, which will be discussed below, gained success through a whole of government system of cooperation and collaboration (Canadian Association of Chiefs of Police, 2020; European Monitoring Centre for Drugs and Drug Addiction, 2019; Henry, 2019). Simply refusing to prosecute possession of illicit drugs while allowing criminal trafficking networks to prosper will likely produce a negative outcry from the public, since the illicit drug market will continue to flourish. For decriminalisation to work, a fully integrated system of collaboration between criminal justice agencies, health, and social services is required to support appropriate pathways of care (Bansback et al., 2018; Banjerjee & Wright, 2020; Canadian Association of Chiefs of Police, 2020; Jesseman & Payer, 2018; Vancouver Police, 2020a). The outcomes of decriminalisation are not necessarily budgetary but could be measured in terms of community wellbeing and a reduction in the effects of crime (Canadian Association of Chiefs of Police, 2020). This approach is supported by the UN General Assembly Special Session (2016) and the UN Office on Drugs and Crime that

advocate not only for a focus on demand reduction, but also a commitment towards a health and human rights-based approach (Henry, 2019; United Nations, 2018).

The concept of decriminalisation is perhaps best captured by the pioneering experience in Portugal in 1999 (Canadian Association of Chiefs of Police, 2020; Hughes & Stevens, 2010). Misunderstanding the concept of decriminalisation may lead society to believe that the policy will create an increase in overall illicit drug use, as police remove their focus on street level drug use (Canadian Association of Chiefs of Police, 2020). The experience in Portugal did not lead to an increase in drug use, and there was a reduction in overcrowding in the criminal justice system and overall drug related harms (Hughes & Stevens, 2010). In their study, Hughes and Stevens (2010) posited that a criminal approach to drug use was actually detrimental to overall public wellbeing. Political reluctance to decriminalise possession and use of personal amounts of illicit drugs have led western countries to focus on enforcement, rather than root causes, creating a system that is not sustainable (Hughes & Stevens, 2010). The use of criminal sanctions in an attempt to treat addictions have repeatedly proven to be ineffective in supporting vulnerable populations and reducing crime associated to addictions and mental health (Canadian Association of Chiefs of Police, 2020; Jesseman & Payer, 2018). The 1999 Portuguese *National Strategy for the Fight Against Drugs* and the 2013 *National Plan for the Reduction of Addictive Behaviours and Dependencies* linked legislative reform of criminal justice approaches to a drug strategy that sought pathways to care for vulnerable populations (European Monitoring Centre for Drugs and Drug Addiction, 2019). Pathways to care included a more humane and compassionate legal framework, expanded prevention policies, and expanded supports, such as housing, treatment, harm reduction, and reintegration approaches.

Supply reduction was a key goal and was achieved through the introduction of a medically controlled, safe drug supply (Hughes & Stevens, 2010). However, implementation of a safe drug supply in the Canadian context is complicated by provincial health regulations and perceptions of decision makers that differ across the country (Canadian Association of People who Use Drugs, 2019). This barrier was not present in Portugal, a country with a single health and justice system, prompting a recommendation by Portuguese officials to learn from their experience, as opposed to copying it (Canadian Association of Chiefs of Police, 2020).

From an enforcement perspective in Portugal, criminal possession offences previously punishable by up to one year in jail were repealed in favour of administrative or public order offences that could be treated through ongoing interaction between the offender and social and health supports (European Monitoring Centre for Drugs and Drug Addiction, 2019; Hughes & Stevens, 2010; Jesseman & Payer, 2018). Since the majority of drug offences in Portugal were deemed to be possession related, a harm reduction and treatment approach was deemed the most effective to reduce demand and subsequent harms. Despite fears that illicit drug use would increase due to decriminalisation, research indicates that, from 2007 to 2017, the usage of amphetamines, MDMA, and cocaine stimulants dropped significantly[1] in the young adult population, defined as those between 15 to 35 years of age. The only significant increase was in the use of cannabis, which remains illegal in Portugal (European Monitoring Centre for Drugs and Drug Addiction, 2019). Treatment was the primary focus of Portuguese drug policy, with 27,150 clients receiving care in 2017. The burden on the criminal justice system decreased

[1] Reductions as a percentage of overall young adult population: Cocaine dropped from 1.3% to 0.3%, MDMA from 0.9% to 0.2%, and Amphetamine from 0.4% to 0.0%.

through the use of medical and administrative approaches that did not use punitive measures against illicit drug users (Hughes & Stevens, 2010). Seizures of illicit drugs by police increased, as they allocated resources to targeting trafficking as opposed to simple possession. Furthermore, there has been a reduction in opioid related deaths and infectious disease that may be attributed to the expanded health and re-integration approach taken, but not necessarily decriminalisation (Canadian Association of Chiefs of Police, 2020; Hughes & Stevens, 2010).

Closely linked to decriminalisation is the concept of a safe drug supply to lower the risk of toxic drug deaths (Canadian Association of People who Use Drugs, 2019). Given the potential toxicity of street level drugs, including cutting additives and fillers, an argument exists for the provision of safe alternatives in support of harm reduction initiatives. The provision of pharmaceutical grade opioids through a treatment program has the potential to greatly reduce opioid related deaths (Bansback et al., 2018; Canadian Association of Chiefs of Police, 2020). A safe drug supply is defined as a legally regulated system to replace the illegal supply. Although it would be difficult to introduce a safe drug supply absent of established decriminalisation options, there is significant research on the effectiveness of providing pharmaceutical grade opiates and agonists (Banjerjee & Wright, 2020; Hughes & Stevens, 2010). This form of treatment may be more effective than traditional programs, such as abstinence, for long-term opioid or illicit drug users (Canadian Association of People who Use Drugs, 2020).

There have been several successful applications of this type of approach throughout Canada. The 2020 Canadian Association of Chiefs of Police report on decriminalisation listed three current examples. The Crosstown Clinic in Vancouver, BC uses a medical prescription

model to dispense pharmaceutical grade heroin or the agonist hydromorphone in an outpatient setting. This approach provides an ongoing treatment pattern with consistent oversight of registered patients. Similarly, the Managed Opioids program in Ottawa, Ontario provides a residential approach to the Crosstown Clinic example. The third example is also in Vancouver, where the Portland Hotel Society provides low barrier access to hydromorphone pills to 50 patients in a supervised setting. The results of these treatment programs have been positive in terms of wellbeing, with a commensurate reduction in overdose deaths, street drug use, and criminality (Bansback et al., 2018; Ivsins et al., 2021).

Harm Reduction to Medicalisation

There is significant research supporting the concept of safe drug supplies within the auspices of harm reduction programs (Canadian Association of People who Use Drugs, 2019). Harm reduction is intended to reduce the potential of death or infectious disease through the provision of safe supplies, including condoms and lubricants, needles and syringes, and alcohol swabs and sterile water, including distribution systems (Buxton et al., 2008). While this provides a traditional understanding of the goals of harm reduction, strategies have evolved from the simple distribution of supplies to the acceptance of supervised consumption sites and treatment programs, such as injectable Opioid Agonist Treatment (iOAT) (Bansback et al., 2018).

The concept of using pharmaceutical grade heroine, known as diacetylmorphine, or agonists, such as hydromorphone, is supported by a growing body of evidence indicating its effectiveness (Banjerjee & Wright, 2020; Bansback et al., 2018). Since it is difficult to maintain oral maintenance treatments, such as methadone, iOAT is an effective alternative that

medicalises provision of drugs away from the street level supply. Although there are variations in application, the general premise is that injectable pharmaceutical grade opiates or agonists are the most effective manner to treat people with severe opioid use disorder (Banjerjee et al., 2020; Bansback et al., 2018). Once such program was the *Study to Assess Long-term Opioid Maintenance Effectiveness* (*SALOME)* to evaluate the use of hydromorphone as an effective treatment option. The study was held in Vancouver, BC for six months and included over 200 participants with severe opioid use disorders (Banjerjee et al., 2020: Bansback et al., 2018). The study determined that hydromorphone was more cost effective than diacetylmorphine, but also identified significant economic and quality of life improvements for participants. In particular, this type of therapy resulted in an apparent drop in criminality on the part of the participants, both in terms of property and violent interactions, although specific results were not available (Bansback et al., 2020).

The SALOME trial built on trials in Portugal that demonstrated similar effectiveness. Banjerjee et al. (2020) compared SALOME to the Portugal trial and three others with similar results, including long-term stability and a reduction in drug use. It was determined that the use of injectable hydromorphone was more effective than the use of methadone in terms of reducing criminality (Banjerjee et al., 2020, Bansback et al., 2018). The participants also demonstrated increased retention in treatment; however, mortality rates remined the same. Overall, the use of hydromorphone was demonstrated to be more cost effective than diacetylmorphine and methadone treatments (Banjerjee et al., 2020, Bansback et al., 2018).

Although SALOME and similar trials proved the effectiveness of replacement therapies, in particular injectable hydromorphone, there is still political resistance to widespread adoption

of the program (Bansback et al., 2018). Trials, such as SALOME, allow for participants to actively engage in their treatment with daily interaction with medical professionals. The need to use street level drugs and the corresponding support for the illegal drug trade is virtually eliminated during the participation phase. The success of these programs can become a working foundation for the implantation of evidence-based shifts in drug policy (Bansback et al., 2018).

Concurrent with the development of iOAT programs is the potential for increased use of supervised consumption sites to reduce the potential for overdose deaths and infectious disease transmission (Kilmer et al., 2018). Although supervised consumption sites may create political and community concerns, such as the perception of enabling drug use and the perception that drug use is a choice that should be stopped, they are effective in reducing the harms associated to illicit drug supplies and present an open door for provision of safe supply and treatment options (Hathaway & Tousaw, 2008; Wood et al., 2006). Despite the potential controversy over supervised consumption sites, their place as part of a broader treatment strategy is warranted, especially with regard to immediate harm reduction, concurrent to the implementation of other strategies (Hathaway & Tousaw, 2008; Hayle, 2015; Kilmer et al., 2018; Wood et al., 2006).

Alternatives to Sentencing

The discussion around reductions in criminality due to effective treatment options is particularly relevant to sentencing. Most street entrenched illicit drug users, if displaying criminality, do so on the lower scale of property crime (BC Justice Review Task Force, 2005). People experiencing homelessness are significantly more likely to experience violence than surrounding populations. In Vancouver, although the homeless population represents just 0.3%

of the population, the homeless are 19 times more likely to be victimised (Vancouver Police Department, 2020b).

It is evident that short term incarceration, especially for minor criminal and drug offences, is not effective (Department of Justice Canada, 2018). The majority of sentences in Canada are imposed on repeat offenders, yet are less than two months in duration (Dandurand & O'Hara, 2020; Malakieh, 2020). This does not provide adequate time to present treatment alternatives or programming to address why a person is offending in the first place. Research in other countries, such as Norway and the European context in general, has indicated that using diversionary programs, as opposed to incarceration, have better long-term outcomes (Jesseman, 2018; Ploeg & Sandlie, 2011). The tendency in Canada to impose short-term sentences is not only expensive, it has little effect on the actual crime rate (Moore et al., 2018). Since the majority of more serious crime is committed by a very small group of offenders (Plecas et al., 2014), it would be more effective to focus on the histories of these offenders to change their trajectories, rather than retribution and punishment. Fully funded restorative justice programs as a primary response to first time offending or survival-based criminality may have better long-term outcomes than a revolving door system (Canadian Association of Chiefs of Police, 2020; Department of Justice, 2018; Ploege & Sandlie 2011).

The Cowper report of 2010 and the following Blue-Ribbon Panel on Crime Reduction (Plecas et al., 2014) emphasised the known vulnerability in certain offender populations and cited the need to place increased emphasis on restorative justice practices. The experience in Norway speaks to the success of moving away from a punitive system based on retribution to a system that is based on reintegration into society (Ploeg & Sandlie, 2011). Case specific courts,

such as Indigenous courts, drug courts, and community courts that see restorative justice as a primary response are important aspects of a move towards wellbeing as opposed to traditional denunciation, since they reduce contact with the criminal justice system through a focus on problem resolution as opposed to punitive measures. In turn, this will reduce police contact with vulnerable populations (BC Virtual Justice Summit, 2020; Canadian Mental Health Association, 2003).

The relationship between illegal drug use and crime is well established (Department of Justice Canada, 2018). The use of alternatives to the normal court process, such as drug treatment courts, may allow for more health-based approaches to addiction and associated mental health illnesses by providing supervised treatment to address some of the root causes of offender behaviour, particularly survival-based offenders, with increased potential to connect them to community supports. In 2018, there were 106 people referred to a drug treatment court program in Canada, a relatively small number compared to those in the traditional criminal justice system, which in fiscal year 2018/2019 was 309,664 (Department of Justice Canada, 2019; Statistics Canada, 2021b).

The use of remand and pre-trial detention has risen steadily in Canada, outpacing the actual incarcerated sentenced population (Statistics Canada, 2017). In most provinces, there is a higher proportion of adults in remand than in sentenced custody, and, in some provinces, such as Alberta, Ontario, and BC, that proportion is as high as 70% (Jones et al., 2019; Malakieh, 2020). The opposite is true for youth, since the principles of the Youth Criminal Justice Act (2003) have resulted in a trend away from remand towards diversion, such as through restorative justice in the first instance, with marked improvement in rates of recidivism for

youth (Malakieh, 2020). In contrast, the trend towards the increased use of remand for adults is troubling in that remand seems to be more punitive than the actual court process (BC Virtual Justice Summit, 2020). Conditions in pre-trial facilities can be considered maximum security with few amenities and no treatment or rehabilitative programs (Statistics Canada, 2017). This seriously disrupts the offender's life, employment, and relationships, with little evidence of an increase in public safety in the near term (Dandurand & O'Hara, 2020). Using restorative justice as a primary means is cited as one method to reduce remand rates; however, electronic monitoring is also effective (BC Virtual Justice Summit, 2020). Powered by modern technology, it presents an opportunity to lower the rate of remand while, at the same time, placing sufficient oversight on an offender, especially if they are undertaking diversionary programs (Plecas et al., 2014).

Changing Perspectives

Although police are often on the front-line in dealing with people suffering from mental health and addictions, there is increasing recognition that appropriate levels of care need to be allocated to these issues (BC Justice Summit, 2017; Department of Justice Canada, 2018). In BC, the *Pathway to Hope: A roadmap for making mental health and addictions care better for British Columbians* (BC Ministry of Mental Health and Addictions, 2019) is an example of a shift away from the criminalisation of these illnesses. It focuses on wellness promotion and prevention, seamless and integrated care, equitable access to culturally safe and effective care, and Indigenous health and wellness. The report indicates that mental health and addictions have an impact of $6.6 billion annually on BC's economy, yet mental health and addictions treatment options pale in comparison to acute and traditional care modalities (Maté, 2018).

Furthermore, the barrier of stigma often prevents people from accessing proper support (BC Ministry of Mental Health and Addictions, 2019; Canadian Mental Health Association, 2019; Maté, 2018; Lancaster et al., 2015; Toronto Police Service, 2019). Stigma is enforced by a lack of understanding of the scope of the problem, a lack of funding for treatment, and a tendency towards criminalisation of the illnesses, particularly addictions (Maté, 2018).

Police attitudes to vulnerable populations have progressed to the point where they are often leading the way in developing solutions and cross sectoral responses (McFee & Taylor, 2014; Vancouver Police Department, 2020b). The ongoing amendments to the *BC Police Act* indicate a strong desire to address current policing issues from a community wellness lens, as opposed to traditional enforcement only options. In his testimony before the Special Committee on Reforming the Police Act, Assistant Deputy Minister and Director of Police Services Wayne Rideout indicated the need to move towards a more collaborative approach to public safety in terms of who should be providing supports and responses (Legislative Assembly of BC, 2021). He articulated that police roles have expanded outside of their core duties due to lack of a collaborative and coordinated cross-governmental approach to issues, such as mental health and addictions. He emphasised the need for health care intervention in these issues, such as expanded harm reduction initiatives and increased communication, and access to information sharing between agencies, such as those found in the Situation Table model (Legislative Assembly of BC, 2021). There was also a recognition of the need to mandate cooperation between agencies to move towards a more proactive approach to these societal issues to shift from police response towards more qualified partners (Legislative Assembly of BC, 2021). While his comments were specific to policing, they were echoed in the recent BC

Virtual Justice Summit (2020) that also called for increased collaboration across sectors, including medical responses to addictions and mental health, as well as alternatives to sentencing for vulnerable populations.

The literature concerning police and justice system interaction with vulnerable populations is in need of an examination into the effectiveness of current approaches to addictions, mental health, and homelessness. Research indicates that new approaches to support vulnerable populations, from addictions treatment to mental health support and housing, are required to see a reduction in police calls for service as a result of public concern over social issues. BC Justice Summits, BC Government initiatives to reform the Police Act, and Government of Canada reviews on justice reforms set the stage to create innovative approaches to social disorder that seek to move away from the criminalisation of vulnerable populations. These approaches should move toward the restoration of dignity in the delivery of community safety and wellbeing. This study was undertaken to identify the need for change toward more collaborative and health-based policies strategies.

Chapter 3: Methodology

Research Question

Statistics indicate that the majority of police calls for service across Canada do not deal with violent offences or even those considered chargeable with respect to the *Criminal Code of Canada* (Canadian Association of Chiefs of Police, 2015; Department of Justice Canada, 2018). Police are often the first response to complex social issues, including addictions, mental health, and homelessness. As a result, criminal justice approaches have become the public's and government's expectation to resolving these concerns contrary to research and developing public policy that indicates these are health and social concerns that require a health or social response. Given the need to allow police to focus on their primary duty of public safety, the research for this major paper examined what leading experts in the fields of public safety, public advocacy, and medical response suggested as policy alternatives towards overall CSWB. When combined, public safety, public advocacy, and health responses can be described as public wellbeing or a collaborative approach to social concerns. Policy alternatives represent medical approaches, collaboration across public sectors, and criminal justice reforms, such as alternatives to sentencing, decriminalisation of illicit drugs, and de-stigmatisation of vulnerable populations.

Objectives

There is a significant body of research with respect to the lived experience of those suffering from addictions and mental health illnesses, as well as those experiencing homelessness. There are also significant statistical data available that demonstrate the response patterns of police and public safety agencies. The intent of this research is to

synthesise those data with the views of service providers, not just first responders, but also those of advocacy and medical practitioners. This study examines current police crime data as a basis for the assertion that police are being overtasked with social, non-criminal matters. This assertion forms the view that there are alternatives to police response as a primary agency based on cross-sectoral collaboration and support to vulnerable populations. This has the potential to decrease crime and increase wellbeing in communities. The alternatives suggested will be based on the input of a cross section of service providers to recommend improvements to current addiction, mental health, and homelessness policies.

Sample Size and Composition

The data for this research was obtained through qualitative interviews with 14 participants. Participants were identified as those with managerial or policy development experience in the areas of policing, mental health, medical service delivery, and advocacy. To be eligible, participants must have dealt extensively, either directly or through their managerial function, with vulnerable populations experiencing addiction, mental health, or homelessness concerns. Participants were identified from a range of experience including police chiefs, front-line police supervisors and specialists, medical professionals, advocacy professionals, and non-government agency service providers.

Research Design

This research followed a mixed methods approach consisting of a data analysis phase, followed by semi-structured interviews designed to elicit the views of participants with respect to addictions, mental health, homelessness, and general social concerns. The data analysis focused on RCMP reported calls for service throughout the province of BC. Crime statistics from

the Vancouver Police Department were obtained through published reports. Data was also obtained from publicly available sources, such as Statistics Canada, to compare policing trends across Canada. These datasets were used to compare calls for service to levels of violent crime, property crime, and social responses.

Participants were recruited using a snowball sampling technique. Snowball sampling is a non-probability technique where research participants identify other participants for a study. The identified participants were introduced to the researcher by the initial participant and subsequently interviewed using the same questions to develop a consistent dataset. A maximum of two participants per agency or direct business lines were recruited to allow for a broad spectrum of views. Once participants were identified, they were asked at the end of the interview for other participants who could offer insight into the research question. Four initial participants at the police leadership level were identified by the researcher due to their public views on these social concerns. Other identified participants included advocacy and medical groups not directly linked to police agencies. Saturation was reached after 14 interviews with participants indicating consistent approaches to developing policy alternatives. In other words, there was strong agreement as to the root causes of the identified concerns and strong agreement as to future policy alternatives. Although the sample size was smaller than the originally anticipated 20 participants, it is a rich sample due to the diversity of participant mandates from police to advocacy groups who were not necessarily in agreement with respect to overall police operations and tactics.

The semi-structured interviews were held using Zoom videoconferencing from the researcher's personal computer, except in two cases where the researcher was in contact with

participants as part of their coincidental duties. All interviews were conducted in English. The interviews were mainly qualitative in nature to elicit the views of participants with respect to root causes and policy alternatives to current police responses and criminal justice approaches to social concerns (Appendix A: Interview Guide). Four specific questions were asked of each participant to compare their views on certain policy questions, such as the decriminalisation of illicit drugs and the need to reduce stigmatisation of vulnerable populations. On average, the interviews were 45 minutes in length and required very little prompting from the researcher as the participants had very well developed views on the subject matter. Responses were tabulated and compared participant mandates across five categories: police leadership, police supervisors and specialists, advocacy participants, medical participants, and non-government agency participants.

All interviews were audio recorded using a separate, secure device after obtaining permission from the participant as part of their informed consent. Upon completion of the interviews, a dataset was developed using Microsoft Excel to categorise responses into themes. The transcribed portion of the dataset used an inductive approach to group frequently repeated findings into themes that were then grouped to compare policy suggestions. This dataset also included direct quotes from participants that were directly relevant to the policy suggestion or current practice.

Ethics Approval and Risks

There was no remuneration for participants, as they were all interviewed with respect to their current roles and responsibilities. Many of their responses and views were already publicly expressed or directly attributable to their agency or area of expertise. As a result, this

research was considered low risk. All participants were advised that direct quotes would be attributed to anonymized pseudonyms with consistent themes attributed to general occupations or groups. Each participant was advised that it was possible that they could be personally identified due to their already publicly known views on the research question. Each participant indicated that this was not a concern, since nothing they stated was in conflict with the mandate of their agency, current law, or their inherent desires to increase wellbeing in their communities. Although anonymity was not guaranteed, confidentiality of the interviews was.

Ethical approval for this study was approved by the University of the Fraser Valley's Human Ethics Research Board (Appendix B: Certificate of Human Research Ethics Board Approval). Participation in this study was voluntary and all participants were asked to provide informed consent that included audio recording of the interview (Appendix C: Informed Consent Forms). Although no participant withdrew from the study, they were all advised of that option. To ensure the protection of participant's information and identity, all data was secured on a password protected drive on the researcher's personal computer or on an encrypted portable hard drive if required for use away from home. Throughout the study, no person other than the researcher accessed raw information from the interviews.

RCMP statistical information was obtained through an RCMP approval process. No RCMP or police data can be attributed to any individual, as it was obtained to indicate general trends as opposed to activities in any specific community. Finally, all participants were advised of the researcher's current status as a senior police officer (Superintendent) in the RCMP, with experience in police leadership dealing with the concerns raised in this research. They were

further advised that the researcher was retiring from policing in the immediate future. None of the police participants were in the direct chain of command of the researcher.

Chapter 4: Findings

Statistical Analysis

Concurrent to the qualitative interview phase of this study, a statistical analysis of current charge rates and calls for service was conducted. The following tables include RCMP data from the entire province of BC. Although data from all municipal police forces in BC are not included, in terms of chargeable call ratios to overall response, the trends are consistent. This was confirmed in discussions with senior police officers in large municipalities in BC, as well as an open-source statistical review of the number of criminal code offences, versus total calls for service. For instance, in 2019, the Vancouver Police Department responded to 265,232 calls for service, 56,780 of which were criminal offences, 1,459 were drug offences, and 1,493 were criminal traffic, such as impaired operation of a motor vehicle (Vancouver Police Department, 2019). Similar to RCMP jurisdictions, this data indicates that 22.5% of the Vancouver Police Department's calls for service were *Criminal Code* related.

The following tables use RCMP data in BC as an indicator of charge ratios and overall crime types. Given that the data represent detachments from as small as three police officers to a detachment of over 850 police officers, there is a high level of confidence that these data are representative of overall trends for the purposes of this study. The focus of this portion of the study is the comparison between the number of *Criminal Code* and *Controlled Drugs and Substances Act* (CDSA) occurrences police attend versus the overall number of occurrences. Second, this comparison is also used to determine the number of *Criminal Code* and CDSA charges that actually develop from these occurrences.

The volume of property crime is considerably higher than violent crime. The number of violent crimes in this data set may appear lower than publicly available data, since each occurrence is counted as one, regardless of the number of victims. The BC Ministry of Public Safety and Solicitor General (2019) describes this difference as follows:

> The number of **violent crimes** recorded is equal to the number of victims involved in a violent incident. For example, when one person murders three people, three offences are recorded. For all **property crimes** and **other crimes**, the total number of offences recorded is equal to the number of distinct or separate incidents. For example, in an incident where several vehicles parked in one block are spray-painted with paint from the same spray can, only one incident of vandalism is reported.

The BC Ministry of Public Safety and Solicitor General (2019) defines clearance rates referred to in this study as follows:

> Crimes are cleared when police have sufficient evidence to identify the offender(s) and prove the offender(s) committed the crime. Offences can be cleared in one of two ways: cleared by charge or cleared otherwise:
>
> > **Cleared by charge:** When the police have identified at least one offender and have sufficient evidence to prove the offender committed the crime, the police prepare a Report to Crown Counsel (RCC) to recommend charges. Once an RCC is forwarded to the local Crown Counsel office, the police consider the incident to be **cleared by charge**, and this status is recorded in the UCR2 Survey.
> >
> > **Cleared otherwise:** In some instances, police identify the offender(s) and have enough evidence to support a charge, yet they do not recommend charges. Such offences are reported in the UCR2 Survey as **cleared otherwise**; that is, the offence is cleared by a method other than by recommending charges to Crown counsel. Offences are **cleared otherwise** for a variety of reasons including: the offender is under the age of 12; the offender has diplomatic immunity; the offender is deceased; the offender has been sentenced for other similar crimes; or police wish to divert the offender from the formal system.

Table 5 indicates the number of occurrences in BC RCMP jurisdictions that were cleared by charge as compared to the total number of occurrences received in the given year. Percentages are associated to founded occurrence records and all occurrence records. All occurrences are considered founded on initial response; however, subsequent investigation may determine the original call type was unfounded. For this reason, Table 5 indicates founded and all occurrences since both are reflective of police response due to required investigational steps. The data in Table 5 indicates that, in the four years from 2017 to 2020, the average of all occurrences cleared by charge, including all enforced statutes, was 6.1%. In other words, on average, of all the calls for service that BC RCMP officers attend, only 6.1% result in approved charges.

Table 5: Occurrences Cleared by Charge*. (E Division RCMP, 2021)*

	2017	**2018**	**2019**	**2020**
Total Occurrences	1,196,463	1,222,319	1,261,309	1,220,847
Occurrences Cleared by Charge	79,224	78,025	74,621	66,823
All Occurrence Records - % Cleared by Charge	6.6%	6.4%	5.9%	5.5%
Founded Occurrence Records - % Cleared by Charge	9.2%	8.7%	7.0%	6.6%

Tables 6 and 7 further break down the occurrences cleared by charge into categories of offences. The most common occurrences cleared by charge in 2020 fall into the "Other Occurrences (Non-Reportable)*"* category (45%).[2] The most common *Criminal Code* occurrences cleared by charge were related to violent crime (18%). Following violent crime, 14% of *Criminal*

[2] Other Occurrences includes a large number of non-*Criminal Code*/CDSA occurrences, such as municipal bylaws, Provincial Motor Vehicle Act offences including non-criminal impaired, driving complaints, warrant execution, summon and subpoena service, search warrant applications, search and rescue, drug overdose, certain non-*Criminal Code*/CDSA federal statutes, boating safety, naloxone deployments, explosive disposal, airport security, VIP security, covert police operations, intelligence operations, community service and education, public complaints against police, assisting other agencies and emergency services, and administrative charges, among others.

Code occurrences cleared by charge fell into the "Other Criminal Code" categories[3]. CDSA and *Criminal Code* Traffic offences accounted for 9% of occurrences cleared by charge, provincial statutes accounted for 4%, and the final 10% of *Criminal Code* offences cleared by charge fell into the property category, even though the number of property crimes far exceeded the number of violent and drug related *Criminal Code* occurrences. For instance, in 2020, there were 166,929 founded property crime occurrences, as compared to 59,327 founded violent crime occurrences, and 18,536
founded CDSA occurrences in BC.

Table 6: Occurrences Cleared by Charge, by Type. *(E Division RCMP, 2021)*

	2017		**2018**		**2019**		**2020**	
Violent Criminal Code Occurrences	14,523	18%	13,818	18%	12,444	17%	11,904	18%
Criminal Code Property Occurrences	9,635	12%	9,186	12%	9,310	12%	6,672	10%
Other Criminal Code Occurrences	12,792	16%	11,958	15%	11,180	15%	9,572	14%
CDSA Occurrences	4,274	5%	3,583	5%	1,996	3%	1,842	3%
Federal Statute Occurrences	565	1%	415	1%	332	0%	329	0%
Provincial Statute Occurrences	3,682	5%	3,367	4%	3,886	5%	2,662	4%
Other Occurrences (Non-reportable)	23,881	30%	25,650	33%	31,370	42%	29,744	45%
Criminal Code Traffic Occurrences	9,872	12%	10,048	13%	4,103	5%	4,098	6%
Total Cleared by Charge	79,224	**100%**	78,025	**100%**	74,621	**100%**	66,823	**100%**

Table 7 indicates that the majority of charges forwarded by the BC RCMP were for non-*Criminal Code* occurrences that include cleared by charge occurrences that fall under the CDSA, federal statutes, provincial statutes, *Criminal Code* Traffic occurrences, and "Other

[3] Other *Criminal Code* Occurrences includes *Criminal Code* occurrences that do not fall into the category of violent or property, such as communication for the purposes of prostitution, gaming offences, weapons offences (not used in commission of a crime), breach of bail/court conditions, child pornography offences, hate crimes (without active violence), terrorism, obstruct justice, impersonate police officer, bigamy, proceeds of crime, and animal cruelty among others.

Occurrences". This follows an annually expected 40%/60% split based on historical patterns that is evident here. Approximately 60% of the cleared by charge occurrences the BC RCMP investigated were not related to *Criminal Code* offences.

Table 7: All Occurrences Cleared by Charge. (*E Division RCMP, 2021*)

	2017	**2018**	**2019**	**2020**
Total Criminal Code Occurrences	36,950	34,962	32,934	28,148
Non-Criminal Code Occurrences	42,274	43,063	41,687	38,675
Total by number	**79,224**	**78,025**	**74,621**	**66,823**
Total Criminal Code Occurrences	47%	45%	44%	42%
Non-Criminal Code Occurrences	53%	55%	56%	58%
Total by percentage	**100%**	**100%**	**100%**	**100%**

It is important to note that Tables 5 to 7 represent the number of **approved** chargeable occurrences, not the total number of *Criminal Code* or other statute occurrences responded to by police. Most *Criminal Code* and CDSA reported occurrences do not lead to charge approval even though any occurrence that is not yet cleared could be chargeable at some point. To obtain a clearer picture of the number of potentially chargeable occurrences, an analysis of *Criminal Code*, CDSA, and criminal traffic offences was required. Table 8 compares the number of occurrences over four years as opposed to those that could potentially have been considered chargeable (i.e., the call that was responded to was initially considered criminal or drug related). It examines total occurrences versus cleared by charge for the categories of violent *Criminal Code*, property-related Crimin*al Code*, and CDSA since these are the most common categories handled at the front-line detachment or municipal level. Occurrences listed in the "other *Criminal Code*" category may be investigated at the front-line level but are often investigated by specialised units either at the large municipal detachment or provincial level.

The data indicate a significant drop in 2019 from previous years in the percentage of occurrences cleared by charge as compared to the total founded occurrences in these categories. This is due to changes in the Uniform Crime Reporting (UCR) system that came into effect on January 1, 2019. Although this makes data comparison unreliable, the data are still instructive in terms of overall charge rates compared to founded occurrences in any given year.

Table 8: Founded Occurrences as % of Total. *(E Division RCMP, 2021)*

	2017	**2018**	**2019**	**2020**
Violent Criminal Code Occurrences Charged	14,523	13,818	12,444	11,904
Total Founded Violent Crime Occurrences	36,416	40,450	59,100	59,327
% Charged to Total Founded Violent Crime	39.8%	34.2%	21.1%	20.1%
Criminal Code Property Occurrences Charged	9,635	9,186	9,310	6,672
Total Founded Property Crime Occurrences	163,154	165,693	193,046	166,929
% Charged to Total Founded Property Crime	5.9%	5.5%	4.8%	3.99%
CDSA Occurrences Charged	4,274	3,583	1,996	1,842
Total Founded CDSA Occurrences	16,176	15,651	18,938	18,536
% Charged to Total Founded CDSA	26.4%	22.9%	10.5%	9.9%
Total Violent/Property/CDSA Occurrences Charged	**28,432**	**26,587**	**23,750**	**20,418**
Total Violent/Property/CDSA Occurrences	**215,746**	**221,794**	**271,084**	**244,792**
% Charged to Total Founded Violent/Property/CDSA	**13.2%**	**12.98%**	**8.8%**	**8.3%**
Total occurrences	**1,196,463**	**1,222,319**	**1,261,309**	**1,220,847**
Violent/Property/CDSA Occurrences as % of Total Occurrences	**18.0%**	**18.1%**	**21.5%**	**20.1%**

The data in Table 8 indicate that in 2019 and 2020, on average, only 8.6% of founded violent, property, and CDSA occurrences resulted in clearance by charge, with the highest clearance by charge rate attributed to violent crime. In terms of calls for service by BC RCMP, Table 8 indicates that violent, property, and drug crime occurrences account for an average of

19.4% of all occurrences in BC RCMP jurisdictions. This does not include *Criminal Code* offences listed in the "Other" and "Traffic" *Criminal Code* categories.

Table 9 indicates that the most commonly reported violent crime was common assault, defined as the least serious of the three types of assault[4], followed by uttering threats, harassing communications, and the more serious violent crimes of assault (Level 2 and 3), robbery, and sexual assault. These serious occurrences require significant investigational time and commitment.

[4] A common assault occurs when an individual intentionally applies force or threatens to apply force to another person without that person's consent. The seriousness of physical injury is what distinguishes this type of assault from more serious assaults. Common assaults include pushing, slapping, punching, and face to face verbal threats (Statistics Canada, 2021). Assault with a weapon or causing bodily harm (Level 2) involves carrying, using, or threatening to use a weapon against someone or causing someone bodily harm. Aggravated assault (Level 3) involves wounding, maiming, disfiguring, or endangering the life of someone (Statistics Canada, 2021).

Table 9: Founded Violent Criminal Code Occurrences. *(E Division RCMP, 2021)*

	2017	2018	2019	2020
Assault-Common	14,362	15,659	21,766	20,941
Utter Threats Against Person	6,243	7,185	13,187	13,408
Harassing Communications	4,020	4,438	7,003	7,661
Assault-W/Weapon or Causing bodily harm (CBH)	4,091	4,393	5,619	6,015
Sexual Assault	1,666	2,111	2,931	2,830
Criminal Harassment	1,107	1,108	1,814	1,679
Extortion	381	770	799	964
Sexual Interference	577	669	882	870
Robbery-Other	654	663	831	752
Assault Police-Common	560	611	620	609
Robbery W/Other Offensive Weapon	548	547	619	582
Forcible Confinement	234	216	228	290
Assaults-Other	154	137	220	239
Distribute Intimate Image-No Consent	100	118	225	230
Assault-Aggravated	236	224	226	216
Indecent Communications	148	253	260	208
Firearm-Pointing	77	82	157	175
Robbery W/Firearm	183	173	197	166
Luring Child Via Computer	73	89	157	158
Assault Police-W/Weapon or CBH	97	101	112	136
Total Violent Crime (Including unlisted crime types)	**36,416**	**40,450**	**59,100**	**59,327**

Table 10 provides the top 20 most reported CDSA occurrences over four years. The data do not indicate if the possession charges were exclusively for personal possession or if they were the result of insufficient evidence for a trafficking offence. Possession occurrences for Schedule 1 drugs that included opiates remained relatively constant over the past four years even when accounting for the UCR scoring changes in 2019. Of note, CDSA occurrences for possession of under 30 grams of Cannabis ceased in 2019 following legalisation of that drug. Importation occurrences, however, increased in 2019. When comparing Table 10 to "*Table 6* –

Occurrences Cleared by Charge", only 4% of founded CDSA occurrences were cleared by charge, on average, over the past four years.

Table 10: Top 20 Founded CDSA Occurrences. *(E Division RCMP, 2021)*

	2017	2018	2019	2020
Import-Cannabis	0	0	2,591	4,222
Possess-Oth Sched I Drugs/Subs	920	1,122	2,418	2,316
Possession-Methamphetamine	1,801	1,875	2,119	2,145
Possession-Fentanyl/Analogs	345	598	880	1,557
Possession-Cocaine	1,499	1,469	1,680	1,378
Trafficking-Cocaine	463	636	1,247	1,025
Possession-Heroin	1,124	1,104	1,286	920
Trafficking-Other CDSA	88	173	669	696
Trafficking-Fentanyl/Analogs	120	279	490	613
Trafficking-Other Sched I	61	93	647	594
Trafficking-Methamphetamine	172	280	356	276
Import/Export-Anabolic Steroid	22	54	209	271
Import/Export-Oth Sched Iv	10	34	255	245
Import/Export-Oth Sched I	38	36	176	184
Cannabis Act-Other	0	0	60	172
Cannabis-Cult/Prop/Harv Adult	0	13	153	158
Trafficking-Heroin	244	158	192	150
Possess-Oth Sched Iii Drug/Sub	143	118	161	138
Export-Cannabis	0	0	3	134
Cannabis-Anything Prod/Dist	0	22	115	112
Import/Export-Cocaine	17	63	96	112
Total Founded CDSA Occurrences (Including Unlisted Crime Types)	**16,176**	**15,651**	**18,938**	**18,536**

Table 11 indicates that theft from a motor vehicle was consistently the most reported property crime occurrence followed by mischief to property, theft under $5,000, mischief loss of enjoyment of property, and shoplifting under $5,000. Fraud, break and enter, and theft over $5,000 round out the top 15 property offences reported.

Table 11: Top 40 Founded Criminal Code Property Occurrences. *(E Division RCMP, 2021)*

	2017	2018	2019	2020
Theft From MV Under $5000	37,588	37,534	39,107	30,572
Mischief $5000 Or Under	25,792	25,351	29,202	29,369
Theft-Other Under $5000	20,285	19,985	23,738	18,284
Mischief-Loss Enjoyment Prop	7,384	8,303	13,991	15,308
Theft-Shoplifting Under $5000	15,626	16,258	20,223	14,212
Break & Enter-Business	7,512	7,544	8,845	7,691
Fraud-Money/Prop/Sec<$5000	5,768	6,551	7,900	7,363
Fraud-Other	4,865	5,586	6,058	5,920
Break & Enter-Residence	8,128	7,517	7,653	5,828
Theft Bicycle Under $5000	4,185	4,762	5,097	4,418
Fraud-Identity	2,293	2,416	3,120	3,382
Break & Enter-Other	3,214	3,425	4,012	3,356
Possess Prop Obt Crime U/$5000	1,718	1,839	3,222	2,815
Fraud-Money/Prop/Sec>$5000	1,595	1,983	2,519	2,414
Theft From Mail	716	1,413	1,706	2,202
Theft Of Auto Under $5000	3,480	2,557	2,511	1,886
Theft Of Auto Over $5000	1,606	1,408	1,409	1,297
Theft Of Truck Over $5000	1,707	1,519	1,541	1,278
Arson-Property	969	991	1,149	1,258
Theft Of Truck Under $5000	1,829	1,616	1,703	1,234
Theft-Other Over $5000	984	1,065	1,201	922
Possess Prop Obt Crime O/$5000	839	823	963	750
Theft From Mv Over $5000	627	630	695	508
Mischief-Cause By Act/Ommiss'n	381	471	558	492
Theft Motorcycle Under $5000	478	450	563	418
Take Auto W/O Consent O/$5000	330	321	437	408
Mischief Over $5000	332	364	441	395
Take Auto W/O Consent U/$5000	342	297	449	389
Fraud-Forgery	384	397	590	385
Theft-Identity	252	316	339	363
Theft Other Vehicle U/$5000	304	328	338	298
Theft Other Vehicle Over $5000	319	334	322	296
Break & Enter-Seasonal Res	307	285	283	288
Fraud-Utter Forged Documents	277	331	365	229
Theft Bicycle Over $5000	103	121	126	133
Theft-Elec/Gas/Tel Under $5000	103	111	138	123
Theft Motorcycle Over $5000	155	144	136	109
Break & Enter-To Steal Firearm	123	100	119	78
Theft-Shoplifting Over $5000	62	45	67	49
Fraud-Real Estate	32	36	40	40
Total (Including unlisted crime types)	**163,154**	**165,693**	**193,046**	**166,929**

Table 12 indicates property, violent, and CDSA occurrences as a percentage of founded and all occurrences. These types of occurrences, which comprise the most serious offences, account for 25% of the founded occurrence volume for BC RCMP jurisdictions.

Table 12: Property/Violent/CDSA as % of Total Occurrences. *(E Division RCMP, 2021)*

	2017	**2018**	**2019**	**2020**
Criminal Code Property Occurrences	163,154	165,693	193,046	166,929
Criminal Code Violent Occurrences	36,416	40,450	59,100	59,327
Founded CDSA Occurrences	16,176	15,651	18,938	18,536
Total Property/Violent/CDSA Occurrences	**217,763**	**223,812**	**273,103**	**246,812**
Total Founded Occurrences	861,130	896,839	1,066,014	1,042,772
% of Founded Occurrences	**25.3%**	**25.0%**	**25.6%**	**23.7%**
Total Occurrences	1,196,463	1,222,319	1,261,309	1,220,847
% of Total Occurrences	**18.2%**	**18.3%**	**21.7%**	**20.2%**

Similar to Table 12, Tables 13 and 14 indicate the total of the top 15 founded non-*Criminal Code* occurrences as a percentage of founded and all occurrences. These types of occurrences, which comprise less serious offences, as compared to violent and property crime, consistently account for approximately 50% of the founded occurrence volume for BC RCMP jurisdictions. The largest occurrence type in this category is false and abandoned 911 calls. Due to changes in reporting, the *query to locate individual* crime type was replaced by the *check wellbeing* crime type in 2020. Any *query to locate* occurrences from 2018 and 2019 after that date, were recoded as check wellbeing.

Table 13: Founded Non-Criminal Code as % of Total Occurrences. *(E Division RCMP, 2021)*

	2017	**2018**	**2019**	**2020**
Non- Criminal Code Occurrences	438,108	463,085	560,088	552,461
Total Founded Occurrences	861,130	896,839	1,066,014	1,042,772
% of Founded Occurrences	**50.9%**	**51.6%**	**52.5%**	**53.0%**
Total Occurrences	1,196,463	1,222,319	1,261,309	1,220,847
% of Total Occurrences	**36.6%**	**37.9%**	**44.4%**	**45.3%**

Table 14: Founded Non-Criminal Code Occurrences - Top 15 *(E Division RCMP, 2021)*

	2017	2018	2019	2020
911-False/Abandoned Calls	63,348	87,286	89,784	80,560
Traffic-Other Moving Prov	66,639	68,627	88,883	83,975
Suspicious Pers/Veh/Occurrence	48,625	48,551	90,410	92,166
Unspecified Assistance	41,264	42,007	63,002	57,607
False Alarms	47,258	45,079	44,257	35,156
Property-Lost	30,846	30,821	31,360	30,955
Breach Of Peace	22,197	21,328	23,366	22,371
Cancelled Files	22,885	21,909	22,682	21,054
Property-Found	21,319	21,317	22,755	18,945
Bylaw-Noise	17,343	17,376	18,852	22,312
Bylaw-Other	14,193	14,725	15,933	17,569
Liquor-Intox In Public Place	14,884	14,447	15,653	10,992
Check Well-Being	0	29	3,374	44,620
Traffic-Other Non-Move Prov	11,022	11,425	12,270	12,159
Query To Locate Individual	14,268	16,140	15,488	0

In summary, the data presented in Tables 5 to 14 indicate the majority of BC RCMP occurrences are not related to criminal matters. The average of all occurrences reported to the BC RCMP between 2017 and 2020 was 1,225,235. Of these occurrences, less than 20% fell into the categories of violent, property, and CDSA offences. Although that is a significant number, only 6.1% of all occurrences were cleared by charge, 58% of which were for non-Criminal Code offences, excluding *Criminal Code* Traffic offences.

The majority of *Criminal Code* occurrences were for property crimes, although this category had the lowest clearance by charge as compared to violent crime and other *Criminal Code*. The most reported property crime occurrence was theft from automobile, followed by mischief to property, theft under $5,000, mischief loss of enjoyment of property, and shoplifting under $5,000. Fraud, break and enter, and theft over $5,000 rounded out the top 15 property offences reported.

Qualitative Interview Results

The data for this research was obtained through qualitative and quantitative interviews with 14 participants. Participants were identified as those with managerial or policy development experience in the areas of policing, mental health, medical service delivery, and advocacy. Participants were identified from a range of experience including police chiefs, front-line police supervisors and specialists, medical professionals, advocacy professionals, and non-government agency service providers.

The interview guide was designed to garner participant perceptions of the role of police in dealing with vulnerable populations, including comments on current drug policies. The interviews were designed to be qualitative in nature to assess participant views. An important question determined participants' opinion on the effectiveness of their agency with respect to its mandate for addictions, mental health, and homelessness. Participants were also asked for their opinions with respect to certain policy alternatives concerning vulnerable populations and Canadian drug policy, including their views on the four pillars approach of harm reduction, education, treatment, and enforcement.

Perceptions of Effectiveness in Working with Vulnerable Populations

It was very evident in the interviews that all participants felt that meeting their agency's mandate on the issues of vulnerable populations, including addictions, mental health, and homelessness, was too broad for any one agency or group to deal with. The four police executives felt they were meeting their mandates in terms of CSWB, although they were very clear that their mandate was to provide overall public safety, and as such none of these issues were particularly a police role. They clarified that each of these issues should fall into the mandates of other government agencies, with the police as a necessary support in each category.

Interestingly, the three front-line officers who dealt specifically with vulnerable populations stated they felt that police agencies were challenged in dealing with these issues. Although they agreed with police executives that they needed to respond to these matters out of a concern for public safety, they were disappointed that there was not more collaboration at the front-line level between agencies. Front-line officers were very consistent in their desire to see increased collaboration, as were the executives.

The four participants associated with advocacy and non-governmental support agencies were also reluctant to consider the three concerns as direct to their mandates. Two agencies did not deal specifically with mental health concerns but agreed with the police participants that increased collaboration was necessary. Another participant felt that without full collaboration, it was difficult to assess any agency against this mandate, since there was so much multisectoral intersectionality in these issues. The fourth participant agreed and stated

their agency was not specifically involved with these groups but had a broader mandate to seek improved policy options to support the rights and dignity of vulnerable populations.

Finally, the medical participants agreed that this question was too broad to answer each aspect specifically. One participant only dealt with addictions treatment and felt that their agency was highly effective, but it did not have a mandate with respect to homelessness and mental health, other than they were often concurrent to addictions. The second participant agreed with this; however, from a mental health perspective. The final medical participant felt the approach to all three concerns was somewhat ineffective due to the lack of coordinated vision to support vulnerable populations.

All participants were provided with a number of policy alternatives and asked to comment on the extent to which they agreed or disagreed with the option. The policy alternatives were: (1) decriminalisation or medicalisation of controlled drugs should take precedence over enforcement in vulnerable populations; (2) reducing stigmatisation is a key target for effective implementation of alternatives; (3) developing alternatives to police responses, such as co-responder models, is an important component of building well-being amongst vulnerable populations; and (4) developing alternatives to sentencing is an important component of building well-being in vulnerable populations. All participants strongly agreed with these policy alternatives and felt they were vital in moving forward with effective support to vulnerable populations specifically, but also those in the general population suffering from any of these concerns. It was interesting to note that regardless of agency mandate, all participants agreed that current approaches to supporting vulnerable populations have gone

too far into criminalisation as opposed to treatment for what should be deemed health and support issues.

All participants were asked for their opinions with respect to Canadian drug policy. The policy questions were: (1) Canadian drug policy should move towards decriminalisation of certain illegal drugs, particularly those at the street level; (2) harm reduction efforts, such as safe consumption sites, are an important component of effective drug policy; and (3) treatment should be available on demand. As with the previous question, there was strong agreement across sectors that Canadian drug policy needed to move away from criminalisation of behaviours associated to addictions and move towards a treatment approach. This question generated much discussion that is incorporated into six themes in the next section. Participants required little prompting to express their views on how to best support vulnerable populations. Their views with respect to the failure of current approaches were evident from the outset, as were their views that investment into solutions was urgently needed. The need for communication and collaboration also became apparent, since all participants agreed that issues around addictions, mental health, and homelessness were far too broad for any one agency, especially if that agency was siloed into one aspect due to funding, legislation, or general practice. It was also apparent that some of the themes are intrinsically linked due to the complexity of the issues. Two specific themes that crossed over the others were the need for cross sectoral cooperation and the need for significant investment into funding solutions to addictions, mental health, and homelessness.

Theme One: Cross Sectoral Cooperation

Participants were very clear that cross sectoral cooperation, collaboration, and communication were urgently needed to address the issues around addictions, mental health, and homelessness. This perception was not just about inter-agency cooperation, but also the need to communicate the overall roles of the agencies to community partners to build understanding about root causes of these issues. As covered more fully in Theme 5: Understanding Trauma, Reducing Stigma, the lack of understanding of the root causes created a tendency towards criminalisation and the use of the criminal justice system to address what the public views as deviant behaviour. However, addictions, mental health, and homelessness were clearly health concerns based on the views of the participants and supporting evidence.

"Blake" is a police executive in a large BC city. He was very clear that other levels of government needed to be active participants in finding solutions to these issues. He stated:

> Do we need other levels of government? Do we need other agencies to step up and provide assistance and take some of that burden away from police? Yes, but it is important to remember that with high levels of victimisation, and some people involved in criminality, the police will still have a hand in those investigations. Regardless, it is not like you are going to take all that away from the police. If you can do a good enough job dealing with the upstream drivers, then hopefully you will have a good impact on the prevention, so you will have fewer people becoming involved in criminality.

One of his counterparts, "Alex", a police executive in another large BC city agreed:

> We are somewhat struggling because we need other agencies to step up. We need [the health authority] to commit to providing us resourcing if we want to make a change. There is a lot of lip service, but not a lot of action, so I hope to have more, a better approach to mental health that we are trying to start up, but I need [them] to step up. So, we are actually looking to go more to a car 87 type approach like a Vancouver model where we have you know, a mental health nurse and police officer.

Upstream drivers were defined as the root causes of behaviours exhibited by the vulnerable population. “Blake” was referring to the need to address these drivers before they manifested in criminality and victimisation. To achieve this, other agencies are required at the table, well before police intervention, in a broad reaching way. “Sidney”, who is an executive with an advocacy group for vulnerable populations agreed. Her view echoed the assertion that upstream drivers needed to be addressed for all people, regardless of their current situation. This included the need to speak with people from affected groups, including those with lived experience:

> I think there is the issue where the board is saying that we want to serve the more vulnerable, but actually they do not. They want to serve a portion of the vulnerable and they want to hand pick. I am saying no, we are going to work collaboratively, but it does not need to be just this sector. We intersect with people doing sex work, people that are non-Caucasian, et cetera. We have to include the high representation of folks amongst the homeless who are like 40% Indigenous people. So Indigenous people have to be involved in the decision making. If we are living with addictions, those living with addictions have to be part of the solutions and the harm reduction. It is like you want to solve homelessness? Ask someone that is homeless. What do you need?

What became evident in the interviews was the identification of barriers to working in a collaborative manner. Despite the desire of many sectors to work together, perceptions and siloed approaches often proved stronger than available evidence. “Reilly” is a senior member of an advocacy group that focusses on the rights of vulnerable populations. She identified that the current system was almost set up to fail due to pre-established perceptions of what should happen, lack of coordination, and the inability of vulnerable populations to succeed in a criminal justice-based approach:

> This adversarial system, right, the law? The court system? It is not really designed to build collaboration. It is like I have my side, you have your side, and now we are going to fight and see who can make a better argument that does not serve vulnerable people at all. They do not have access to that system. They do not even use that type of language

> or vocabulary. So now we are just talking about you up here and you are still struggling down there.

Medical professionals concurred that the current system was rife with bureaucracy and difficult to navigate for vulnerable populations. Even more troubling was the lack of broad support for vulnerable people, even if there was a recognised need. “Jules” is an executive at a regional hospital and stated:

> So, when you think of BC housing, there's multiple departments. You have got Community Living BC; you have got Ministry of Children and Family Development. Now you have a Ministry of Mental Health and Substance Use, and those ministries do not coordinate together. They all have levels of hierarchy and administration and now God forbid add the new First Nations Health Authority. Unbelievable bureaucracy.

Much of the concern was due to the siloed approach in social support networks, even though a certain amount of this was viewed as necessary. For instance, police have a direct mandate to investigate criminal offences and the BC Ambulance Service is directly mandated to provide emergency paramedical service in the field. This is understandable; however, the lack of organisational or political will for each agency to collaborate outside of their specific mandate seems to have perpetuated the notion that the agencies should operate independently. “Jules” went on to say:

> Our job is not to address social issues, but quite often we have no other people at the table for us when social issues intersect with health issues. For example, the person who happens to be homeless and now needs medical treatment but needs to be discharged back to a homeless situation. There is no wrap around supports to do that. We are not a housing agency under our provincial structures. Healthcare is not housing. That is BC housing and other municipal or other provincial and municipal departments.

“Jules’” frustration was not borne out of a lack of willingness to help, but from the inefficiencies in the ability to connect urgently with agencies that could or should help. The hierarchy and bureaucracy were also identified by other participants; however, they qualified

their concerns with the understanding that people in those ministries and agencies truly wanted to help, but their mandates were either too broad, or not aligned with other agencies who could support them. “Drew” is a police executive responsible for provincial policing who faced similar concerns with his police peers and other participants:

> My overall perspective is obviously we want to help people and get them out of that path. But the reality that maybe what some really well-intentioned people in the industry do not realise is we can’t just ignore that individual user and say why are you wasting your time on that one person? They may have an addiction, but when they are causing that much chaos in the community, we need to do something. We as a community need to do something. Often it is left to the police because they are committing crime, right?

While police and health officials have concerns with the current balkanized approach to community safety and wellbeing, it was telling that their concerns were aligned with advocacy groups and frontline workers. “Robin” has worked extensively with large police organisations to increase their understanding of vulnerable populations, including the development of outreach programs. She agreed that the current system did not have enough intersectionality on an urgent basis. In her view, everything took too much time:

> There is so much that is lacking. I think that is part of why there is no action and why we sit around tables and we all nod our heads, but this is not working, and although we should not be doing things this way, it is just so hard to see the next step. There are so many to choose and so many competing interests, right? I mean, if you think about it, how do you prioritise one group over another? It is not going to be politically smart to prioritise people who are considered to be “lesser than” in our society. Our society is not going to support politicians or others who come forward as champions of those groups.

“Robin’s” perception was echoed in the experience of “Drew” who provided a compelling example from a community where he was the Chief of Police at the time:

> One day we did an exercise with a number of agencies, be it ministry, for profit, non-profit and everyone else who were trying to help people, like low income housing, homeless people. There were 13 separate agencies in [the town] that had housing on

> their mandate. Not talking to each other. All in 13 separate directions, because they are chasing grant money, they are chasing their own objectives. Why work with you if you are going to take some of my business away? It is like Burger King working with McDonald's on a new a new, you know King Mac, right?

"Drew's" counterpart, "Taylor" expressed similar concerns with the siloed approach to finding solutions. He is also responsible for policing initiatives at the provincial level after being the Chief of Police in a large BC city. He stated that many groups were interested in helping vulnerable populations, especially with respect to something tangible like housing, but there was not enough cooperation and understanding within the various roles:

> And there's certain special interest groups that come in for valid reasons, but oftentimes their involvement can exacerbate the situations that the police are trying to solve. For example, we were very open about our plan to clean up the strip, by which we meant find alternative housing. We were very open right from the start because we knew we would be in potentially an uphill battle. So, we engaged with [various] groups, brought them in and told them our plan well in advance. We explained these are the rules we operate under. We are respecting someone's tent; it is their home. We are not just barging in, but we are trying to create engagement. I think that approach was very successful when it came time to actually transition from [the street] to housing.

Another illustrative example was provided by "Clarke" who is a physician involved in iOAT programs in BC. In his case, the resistance came from within the health agencies themselves:

> Well, I can tell you, 20 years ago, when the first [iOAT] study was raised, there were medical professionals who were openly hostile to even asking the question whether prescription heroin would be an option. Over the last five years, there is still sort of quiet opposition, but with this, with the solid evidence, I think we are starting to see growing allies. Not just among physicians, but amongst the other health professions as well.

Most participants expressed the view that programs around addictions, mental health, and homelessness were improving, but there was still a long way to go in terms of developing effective cross sectoral approaches. "Clarke" went on to say:

> I guess ideally moving them to the appropriate system is the way forward. So, if it is the criminal justice system, and sometimes that is the appropriate approach, but if it is the

> diversion from the criminal justice system to care, and medical care in a sort of case management team, then we should have those doors available to the police. Yeah, I think we have had a couple of referrals, so people that the police have taken to our door and introduced them as this is a place you might want to check out.

"Charlie" is a mental health professional who worked in hospital psychiatric units and in private practice. He was concerned by the lack of understanding with respect to vulnerable populations, especially with respect to root causes of behaviours and the ability to engage other sectors in a collaborative manner:

> Most of [my experience] has been related to the dual diagnosis of mental health and addictions. In that context, I played a key role as the hospital liaison to community resources, and managing and planning for marginalised individuals, particularly with mental health concerns. In most cases those also involved addictions or pre-addiction kind of behaviour. Truly, it is not my mandate, but there are very few, if any, points of access to them that are effective.

The lack of connection to various supports has societal ramifications but could also lead to more dire consequences than those already faced by a marginalised community. "Taylor" was concerned not only with the lack of coordination, but the difficult position police were put in when they became the first response to crisis medical situations:

> They are either threatening self-harm or they become a threat of harm to others and the police are responding. We have a considerable amount of de-escalation training that our officers are provided but de-escalation does not always work. Ultimately, many of our officers are put in a situation where they are going to have to use force to deal with a mental health issue, either to protect themselves, to protect the individual that is experiencing the crisis, or the public. It is tragic and oftentimes that ends in fatality or significant injury.

The issue with reactive only approaches is that they often come too late. "Blake" expressed similar concerns:

> It is [co-responder] good for that type of call, but the ones that I am more interested in are the calls like where we have got somebody that has been shot by police. We have had already two officer involved shootings this year. Both, but one more so than the other, had a huge mental health component to it. Police had to unfortunately shoot this

> person that was charging at them with a sword and going to kill a police officer. So that will have to be investigated but let us back it up six months. How did that person get to the point where they are naked, standing in the middle of [the street] covered in blood, smashing up windows, running around with a sword completely out of their mind? Like how does that person get to that point? So, [the mental health car] is going to do nothing for you at that point.

The tragic consequences of poor collaboration were a primary concern; however, expectations could also come into play when assessing the role of police in dealing with vulnerable populations. Police leaders and front-line officers agreed that it was often difficult to balance community expectations with the time it took to respond to so many occurrences, many of which were either outside of their mandate or required collaboration to resolve. “Taylor” went on to say:

> It drains police resources that should be directed to other areas. The police do not necessarily have all the training they need to deal with those areas and those issues, but we are kind of left holding the bag. If there is an issue that a member of the public sees or that is being experienced in an area, everybody knows the phone number. It is just 911 and they know someone is coming. Does not matter if that person is trained or if they are engaged, somebody is coming, some representative, some third party is coming that will then be left to try and deal with that issue, and the amount of time and resource drain that creates is incredible.

“Avery” is a senior police officer who, at one time, worked under the command of “Taylor” in the same large city. He was directly responsible for interacting with a growing homeless population, many of whom suffered from the typical hallmarks of mental health and addictions. He saw first-hand the effects of these afflictions and wondered why change was so slow to come, despite the growing crisis:

> I think that as we move forward, we need to start to address the underlying issues, right? We need to start, and I think we do. When you look at a serious gang squad, they are starting in schools and they are having these conversations with people. And I think you know the school liaison officers are in the schools trying to establish those relationships. So, I mean, I think we are working that way. But there needs to be more

> collaboration, 100% more collaboration within our own house and with the health authorities.

Despite the consensus that collaboration was lacking, all participants recognised that things were improving, albeit slower than they would like to see. Much of their explanation for the slow pace of change dealt with political will and investment. As front-line workers, medical professionals, and police officers, they identified the steps that needed to be taken to move away from a punitive approach; however, in their view, this required large scale collaboration, even to the level of legislation. “Skylar” is a director in an advocacy group that focusses on supporting vulnerable populations, particularly marginalised women involved in the sex industry. She expressed the need for increased outreach as a building block for change:

> What are the responses needed for these people? What is actually happening? When it comes to policing, and no housing, and gentrification, what is happening to them is much more difficult to pinpoint. People living in this reality do not just have one response. So, what does safety mean to you? I know we are unpacking this one thing at a time. We can discuss all of those things too, but having mobile units and foot outreach, community-based teams, [Emergency Medical Services] prepare for a multitude of issues right now is really important to me, because I do not see any of these issues going away any time soon. And, what is the police role in all of this?

“Skylar’s” concerns were echoed by “Reilly” who questioned why police had become such a primary response to societal issues, as opposed to support:

> In some ways, in some small ways, I empathise with police because I think they're the only agency that's available 24/7.They're the only ones who can do certain things. You are dealing with, like, the end of the line in terms of every other institution failing people, but at the same time I do not see the political will from police, RCMP, municipal, provincial, federal to actually distribute some of their massive budgets to community-based safety initiatives.

Participants in this study agreed that the primary role for police was public safety, but that this had shifted so far into responding to mental health, addictions, and homelessness

matters that it would take time to achieve any kind of redistribution of efforts. As “Skylar” stated:

> People say that if someone is screaming and yelling, we do not know if they have a weapon, we do not know who to call [other than police]. And it is that pigeonholing and social profiling of this entire community. Unpacking this is going to take a while, but I think what the role [of police] is, it is responding to immediate safety and harm and then assessing when they get on site to wherever they are with the person. I am wondering if they had the resources to call the nurse or doctor to send them in? I do not see a lot of people opposed to the initial assessment of safety in the area.

Defining how to deploy police resources in support of vulnerable populations was also identified as a challenge. Although all participants agreed on the primary role of the police, they recognised that the requirement to connect vulnerable people to services unfortunately often defaulted to the police. “Jordan” is a front-line police officer in a large BC city who is tasked with outreach to marginalised populations:

> I think we have missed a whole bunch there. There are people who have probably been in places like [rundown single room occupancy buildings] for I do not know, like 8 to 12 years and they are stuck. You got your house, you are done. You are off our radar. We do not care about you…we all do it. We all drive the [police prisoner] wagon for a while and then we get out on the street, right? So, there is that buy in, and I just I thought, man, you know it would be nice if we connected because then we would have people in that mid-range who still have a chance at, you know, making something out of their life for being in a nicer place or a better place, a healthier place.

Once again, the question was one of who should respond, or in the case of 24-hour response, who could respond in an appropriate manner. This often revolved around the ability to arrive in a timely manner. “Skylar” spoke about the benefits of ACT teams, but pointed out they were limited when time may be of the essence:

> And ACT teams do not respond straight away. That is the thing, it sounds great, but they do not have the resources to be a response team. We get participants who are working on [a major road] saying, I think I am in trouble. I am scared. They have to go find them, but they are not emergency response. So, they are on the phone with them.

Participants agreed the solution relied on identifying who was responsible for specific aspects of societal issues, but not in a siloed manner. Responsibility, in their view, did not mean any particular agency was on its own, it was simply a recognition that certain agencies were better suited to move towards an effective resolution to a problem, contingent on collaborative support. As "Drew" stated from a police perspective:

> Use what you can in your own community as a multisectoral effort because we do not own mental health, we do not own homelessness. But we are a piece of the pie, right? You have to contribute, but that can be the hammer and the hug if you will. The hammer is we just charge, charge, charge and force our way out of that issue. Or the hug where you try the wrap around approach. We try to get everybody to understand that person and why they are in that state, and how can we try to help them.

Throughout the interviews, examples of successes were offered as the way forward in building collaboration. Police participants often stated their initial willingness to cooperate with other agencies was a key component of building a collaborative relationship. In other cases, supporting agencies wanted to help, but they did not have a direct connection to specific vulnerable populations. "Avery" again used an illustrative example of successful collaboration with a large homeless population:

> And then we looked at [the health agency], right? I mean, the biggest piece of the puzzle here is addiction, mental health, and crisis. As a police officer I can deal with that and we are incredibly good at dealing with, maybe deescalating, in the moment. But we do not deal with the underlying issues whatsoever, so it was most important establishing a relationship with them…so one of the things that we really needed to look at was collaboration, because we had never done that. We had always worked in a silo. In fact, I can say we had an almost acrimonious relationships with a lot of the social services down there.

"Avery's" counterpart "Jordan" had a similar example in another large city with a different health authority on the importance of maintaining relationships and collaboration:

> It is not just treatment, it is not just getting you away from the substance, but it is what next? Because what are you going to do? You are going to come right back down here again. The ministry is paying for it while you are at one their facilities, but there needs to be more like a planning and staged approach. So, detox needs to be planning for recovery, and recovery, while you are in there, needs to be planning for your next steps like your second stage housing. There are a lot of people down here who are ready to go into something like that and can manage their housing by themselves and can do things like that. Free up some of the sorrows.

As a recurring substantiation of the need for increased collaboration, "Blake" and "Avery" offered approaches to working together across sectors. In "Blake's" view:

> Hey, we need way more of it. I think that we do need more coming in from the healthcare stream, but I do not agree with this idea that police should be totally eliminated from it because I think we add a lot of value to it, right? I do not think it should be our main bailiwick, or that we have to take the lead on it, but I am happy to be secondary on it. We need to be part of that conversation with health, and if they are going to come in and take on more of a role, which I would love to see.

"Avery" worked with a health authority in a different city and echoed "Blake's" approach, especially in terms of gaining support from other social service organisations:

> We started to really see that there were some holes in the way we were conducting business, so it was always about re-evaluating what we are doing. We committed to a course that we developed with [the health authority]. They were phenomenal.

"Avery" went on to say:

> The number one thing I needed to do it was actually just start to actually listen instead of talking. So, I established kind of this core working group. I worked with a local society which was our biggest social service provider down there. I went to them first and got buy in from them. I went to this urban mission and got buy in right away from [them]. Then I looked at other faith-based organisations. We had some other faith-based groups down there that were always feeding people, so we talked to them about establishing a relationship.

Participants agreed that effective collaboration required a new approach to destigmatising vulnerable populations. Most participants agreed that simply forcing someone into treatment or insisting that they become "clean" was an outmoded approach to people who

were actually suffering from a recognised illness. Many participants expressed their dismay at the societal belief that addictions and mental health illnesses, particularly those manifesting as homelessness, should be dealt with harshly since they were viewed as a choice, despite evidence to the contrary. “Blake” provided an example of how compassion and understanding of the actual illness could change the trajectory of a person, either newly experiencing substance abuse, or with a lifelong history of social disorder:

> If you are 55 years old and you have been using heroin for 35 years, there is a very low likelihood you are ever going to get off heroin, like very low. That is the way you are going to be for the rest of your life. And the healthcare professionals know that. The doctors know that. They tell me that. So, for that person we have to do something different than we do for the 18-year-old. That person needs to be on drugs the rest of their life, so let us get them under a medical regime prescription. Whatever it is to help them have a better path in life. The 18-year-old? Let us go full out to full on recovery treatment. And you know this person, the 55-year-old, they never have to go into a treatment bed. We just need to get them on a track where they come and see us, and we get him on track. This person we need like acute intervention. And let us save this 18-year-old before they become the 55-year-old down the road or dead before that.

The perspective offered by “Blake” was shared by other participants. From an advocacy perspective, “Robin” explained the futility of using the justice system to resolve social issues. She stated it simply created a cycle of disorder as opposed to actually addressing the root causes. While this may appear to work on a response basis, it did little by way of long-term intervention:

> It is a cycle; it just simply continues. Like the no go rule is one of the most ridiculous rules that we would see for [vulnerable] people. Their dealers and their support services are in a particular area, and then we say no, you cannot go in that area for the next year. I guarantee that person is going to breach that order, so you are creating more things with which to criminalise people. So that person is just going to try to avoid police more,

> which makes them more vulnerable in the community, and it does not address any of the issues that the community is actually most concerned about.

Participants agreed that alienating vulnerable populations from their support systems created additional problems over and above what justice approaches were trying to solve in the first place. Police participants agreed that creating adversarial barriers to interacting with these populations separated them from their primary mandate of public safety and further exacerbated the community concern with crime. To address this dichotomy, "Avery" stated:

> So, we actually did something very unique…. we brought all the homeless people into one area and had a 24-hour police presence. The idea behind it was to assist these people, fast tracking them into services if we can, and then also protecting them. What we were seeing is these drug dealers would come down there and they would assault these people. So, we actually went about finding all these other encampments and inviting them to the [street]. And we did. We ended up having about 95 tents and a little over 200 people living on the street [under our protection].

Using treatment approaches as opposed to a criminal justice approach was viewed by participants as a recognition that illness could not be resolved through enforcement. While the police executives interviewed stressed this repeatedly, evidence continued to build on the front-line. Similar to "Blake's" example, "Kennedy" saw the change in an otherwise incorrigible, yet marginalised individual. At the time, "Kennedy" was working as a police mental health liaison officer with an ACT team in a medium sized BC community:

> He was prolific. He burned out an entire building, but when he was on medication, he was fine. He was housed. He kept everything together. He did not bring anybody to his house and the voices were not talking to him, but it comes down to that support. The ACT team gave that support…We were able to kind of swing him back into the right place and he stopped committing crime. But now, he is completely off the rails after he lost his housing. He has got no goes to just about everywhere right now and he has just completely all gone off the deep end and it is so hard to watch it. I do not think that [police] have enough manpower to be able to fix that problem by themselves. Community supports like the ACT team, as well as proper places, that at the moment that they need to get clean, that place is available. I don't have to tell them that you will be homeless for another month because I lost that person at that moment.

"Kennedy" offered a good example of the effectiveness of co-responder models as a means towards collaboration. The research indicated that ACT teams were more effective in a proactive as opposed to reactive manner, with coordination between police, health, and social services agencies viewed as a net gain. For instance, "Charlie" explained the value of being able to deal with an emergent situation through a co-responder model, with each part working in concert with the other:

> I think they have to be brought together [to the scene], I mean having mental health workers going out with officers, recognising the immediate situation. I mean obviously the safety of the issue for both the public and the individual is often the first response. The first level of assessment. Then what is the need of the individual at that point? I think that is where there needs to be alternative ways of managing situations by assessing the mental health risk and identifying alternative ways to move that person into supportive services if that is necessary.

Co-responder models were effective, but they did not always need to be police led. As the research indicated (Norris, 2019), the presence of police at a situation may have a detrimental effect if not managed properly. "Skylar" stated that other agencies could be equally effective if there was not an immediate need to address safety concerns. Similarly, "Reilly" offered the importance of recognising the lived experience and trauma of marginalised communities with a view to developing responses that were not "one size fits all":

> Yes, so for the co-responder model, I think the concern remains the involvement of police and the delivery of what is clearly becoming mental health services. So why are police attending those calls with someone else? And I think on top of that, it is very dangerous to assume that the mental health system is safe in many ways. We know there is a provincial enquiry that took place around anti-indigenous racism and healthcare institutions, so that is a huge piece of it.

Despite "Reilly's" cautionary advice, all participants recognised the need for increased investment into collaborative approaches. Police executives were primarily concerned that

there was not enough collaboration, often resulting in the need for police to take the lead. Although co-responder models were effective, when used specifically within a social disorder context, such as when they stem from a 9-1-1 call, they could become overly reactive. “Blake” articulated this well:

> You know it frustrates me when I see people toting a car 86 or 66 or whatever you want to call it in your jurisdiction, like this is something leading edge. Partnership cars with police and mental health nurses? We started doing that 1978. That is nothing new. Doing it forever. The Americans are hilarious because, you know, they come out in 2020 after George Floyd. Oh look, now we are doing these partnership cars. It is important, it does an important job, but it is reactive, so you are waiting until somebody is having an episode, somebody is in crisis. Somebody calls 911, we need the cops, and we need health professionals.

When asked about the way forward in addressing collaboration, all participants agreed that communication between government agencies, support services, and the vulnerable populations themselves was key. That last component was echoed throughout the interviews. In the view of the participants, the urgency to address the social issues of addictions, mental health, and homelessness often created the situation where solutions were proffered without speaking to the very people who they intended to help. For instance, “Sidney’ expressed concern with not respecting cultural needs when developing solutions:

> It is unbelievable that we do not think about these things globally. They are all separate siloed decisions. What about the First Nations courts, right? We want diversion, we want restorative justice, and we want traditional cultural ways. There will be times when incarceration is needed. There will be times when apprehension is needed. But we need to build the capacity. In some areas of this country, First Nations reserves have said they want to self-govern. They said we want our own child protection and the [Federal] government in their wisdom said okay, here you go. They had no capacity, so they fail because how can they take over?

There was consistent agreement in the need to build capacity and create investment. This was brought out extensively in Theme 4 that discusses the need for significant investment

and resources; however, collaboration does require a broad approach to providing service. As stated by “Taylor”:

> I think you need that continuum of service. You need to have the ability to react for issues that are coming up right away, but I think you need the stakeholder engagement. You say we are one cog in this wheel in terms of how we manage these problems. We need a commitment to actually address the issues, not only just from an individual agency or stakeholder point of view, but also in terms of backup, research, funding, and commitment. What is our collective approach? Who owns what piece of the pie? How can we information share? Work together to deal with these issues? I think that is the best way to go about it.

Coordination of effort was a key point of agreement among the participants in this study. Advocacy participants agreed that community partners needed to share information and work together towards a common goal. While they may all have that intention, barriers, such as funding, created situations where they needed to be protective of their own program. While this is in part funding related, it is also a function of existing laws and policies. “Robin” pointed out that existing legislation created barriers that could only be rectified with political will and funding:

> But yeah, we need a different solution, but we also need to look beyond simplistic interactions to critically examine those laws that are in place. Fundamentally we need to look at support, both financial and political support.

“Skylar” agreed with the need to move forward with solutions:

> How much does it take to undo 50, 60 years of trauma for some people? …There are all these recommendations in every single report that is almost based on advocating to provincial and federal governments…If I see one more gender-based violence report that has all the same regurgitation of the recommendations that were never met? That is there too when you look at the mental health reports …but these recommendations actually have not been met due to administration changes, due to shifts in policy, due to pandemics. It is about is coming together and looking at the answers that are already there.

Participants stated that collaborative efforts needed to move beyond good intentions and a desire to help into a concrete, government-led action plans. Participants in this study recognised that good intentions alone cannot solve a very complex situation that requires coordinated, multi-faceted approaches. “Charlie” came at this through a treatment lens:

> There is no one size fits all that is right. Every region, every area probably needs to be handled differently, although some of the principles are the same right? But yeah, everybody needs something that uniquely fits who they are and what they are dealing with. How much of their issue is mental health versus addiction, and all of those things even plays a role in deciding what a person needs. I think of greater coordination of services too. Communication between key players and parties, but I think that has always been an issue…I understand there's other things that are high priority too, but somehow, we have been very short sighted in letting these things continue to slide.

Participants agree that building collaboration took time, but the seriousness of the situation required an urgency in the development of effective partnerships. “Blake’s” experience as a police executive highlighted the need to move forward with urgency:

> Yeah, so I think a lot of people have good intentions. I think a lot of the discussion that has been happening over the last year in particular resulted in a police focus. I think health in many cases was a silent partner, but the way that we have dealt with it here in [this city] is that our relationship with [the health authority] right now is outstanding. It was not always that way. We have built those relationships over time and we have a program which is regular meetings between police executives, the police board, health executives, and [the] health board. So, you know I was getting tired of going to these meetings where you have got some manager, or some director, meeting with an inspector and then they talk about these things, and nothing ever happens, and it gets stalled in the chain. We need the chair of the board there and we are going to sit down, and we are going to give some presentations and we are going to make decisions right in that room before we go…we talk about these things and we get the decision makers there and then. Yes, it is improved.

Participants agreed, regardless of their background, that siloed approaches needed to be set aside in favour of solutions that examined the overall wellbeing of the individual and the community. They agreed that current approaches needed to develop beyond individual

mandates to one where doors of support were opened, regardless of which agency initiates the discussion. As “Jules” aptly stated:

> If I was king for a day, I would make a proclamation that nobody will die in the province of BC alone, or with addiction, without us actually being there wherever they are at to support them. If we were to have done [what was done for COVID response] with mental health, we would be saving lives. It does not mean we are not saving lives now, but we are not saving enough.

Theme Two: Barriers to Community Wellness

The need for collaboration was emphasised by all participants, so the question was why is it not more prevalent in communities? When asked this question, participants pointed out the need for funding and increased resources. Secondary to funding, societal expectations and a lack of political will were reported as significant barriers to building community wellbeing, particularly in vulnerable populations. Concurrent to this issue was the sheer amount of work that needed to be done, which was expressed by most participants. “Sidney” summed up the overall sentiment for this theme by stating:

> We all know what has to be done, so why are we not doing it?

Most participants agreed with that statement, answering the question as a function of workload. Police executives were clear that an inordinate amount of time was spent on non-criminal and non-chargeable calls for service, which was backed up by police reported crime data, as presented in Tables 5 through 14. Although they recognised that call volumes are not necessarily indicative of overall workload, they stated that every call for service for social issues took up police time that could be otherwise allocated to more serious community safety issues. They stated that criminal offences took longer to investigate, even when they did not lead to charges. In the view of police leaders and front-line officers, their time should give priority to

criminal and chargeable offences, as opposed to social issues, even if they were less time consuming. “Alex” described part of the issue as follows:

> We arrest [him] every single day for SIPP (State of Intoxication in Public Place) and we are begging the health authority to help us. We are getting nothing, so you know, he is going to die in jail, and we are going to bear the responsibility. It frustrates me to no end that there is no accountability. It is left to the police to manage someone who is truly in a health crisis, until you only punch somebody on the street and then we have to go. So yeah, I think health as a support services needs to be held accountable

Other police leaders expressed similar frustrations with the distribution of workload. “Blake” stated:

> More and more time is spent on issues that are non-criminal. You know that percentage will vary from 25%, 30%, or 40% depending on the agency or bona fide *Criminal Code* offences. The rest is social issues we are dealing with or things that will have a nexus to social issues. The percentage of calls that we deal with that have a nexus to mental health and addictions is high. There is also a high number of people that are from vulnerable populations that are much more likely to be victimised, I think.

Many of the issues with workload were expressed as resulting from societal expectations. Police leaders felt beholden to the current system, since there was no one else to do the work in the first instance. “Taylor” put it this way:

> We cannot avoid coming. You know, if someone picks up the phone and calls 911, we are coming. We are obligated to attend and then once we are there, to disengage if it is not a police matter is very challenging, right? If there is an apprehension in the middle of a call, we cannot leave that individual alone until a doctor actually signs off on them, right? So that could mean waiting six hours at the hospital to get that person either signed in or apprehended medically, or just turn around and released through the revolving door. It creates, and I am just saying this in a general sense, potentially a reluctance among police officers to apprehend or to deal with the critical issue of mental health because it is going to take up half their shift or even longer, and by and large, once they do go down that process, that individual is not treated but released. Why am I bothering to deal with this crisis?

"Drew" expressed the concerns from the front-line officer's view as well, indicating that workload often prevented effective response, even though mental health should not be a primary police response:

> Do I have three hours to deescalate you, or do I have to do this in three minutes? That is a barrier to doing an effective job, and that I am sure that does happen, knowing the demands that are out there. So, the barrier is lack of time to effectively deal with some of these situations as well. Even if there is not an emergency going on, knowing that I have to get back to the office and do this report to Crown because I arrested someone earlier in the shift.

The frustration was not just on the part of police, but by medical professionals as well, who thought there was a link missing in the system between health approaches and accountability for responding. As "Jules" stated in his hospital executive role:

> Our mandate is not with social issues, our mandate is health and quite often many people confuse health with social issues. I will give you an example. At times you know, municipal leaders do not understand how the health care system can actually turn people away from the emergency department who have terrible social issues. While we have social support for them like social workers, if there is not a bona fide medical, or emergent or urgent medical issue, particularly around hospitals, we cannot hold people against their will, and I think that is a real big misunderstanding.

The concept of missing linkages was echoed by "Blake" who expressed the need to develop the political and agency will necessary to assist those in need, while building collaboration on the front-line:

> It can happen if you get the right decision makers in the room, but the big barrier is going to be money, so a lot of these programs could be even better than what it is now if we had more police involved and more health involved. People say, well, why do you need the police? Okay, you could try and do it without the police. The reality is that a lot of these cases, these mental health professionals are not going to go into these situations without the police. They actually like having us. We were in plainclothes and we put officers in there that are not like grunts. We put officers in there that are very thoughtful and talk to people. You cannot tell which one is the cop, which one is the psych nurse, and they just talk to people, and you know, schmooze them and have respectful conversations with them. And it works great, just like anybody in society.

Although workload was expressed as a significant barrier, the lack of funding to break out of siloed approaches was considered problematic by most participants. This was compounded by a lack of understanding of budgetary delegations to the police and the time it took for investments to come to fruition. “Blake” went on to say:

> I know everybody keeps talking about defund the police. Take the money from the police is not about taking money away from the police, it is about we all agree that we need more money in this area. Over time, if you have enough of an impact that you are affecting those upstream drivers of crime and we need fewer police then so be it. But right now, you cannot, in the current system, hold the money from police and think you are going to put it over there. Maybe not a full generational change, but close to it. Like you probably have a full decade, at least, till you are going to see real results here. But you need an infusion of money on the health side is where you need it. That to me is the biggest barrier right now.

Taking money from the police and putting it towards social issues was mentioned by several participants. Police leaders and front-line officers believed this approach was only applicable after significant investment in social and health supports to lessen the upstream drivers mentioned by “Blake”. “Alex” agreed by stating that the issue was compounded by the availability of response. He was amenable to effective distribution of funding; however, he stated in the current system, the only response was by emergency services:

> So, you know, I think we have done ourselves, no not we, the community a disservice by some of the rhetoric that has gone on about, you know, not trusting the police and the police present evil. Every police officer I know truly cares about trying to find, and help, and support individuals. So, because we are 365, 24-7 we will often be that first connection for an individual.

How those connections are manifested was a recurrent issue for all participants. They all stated it was difficult for a marginalised person to access supports without coming through a government agency, particularly the police. Although this will be covered further in Theme 4: Investment and Resources, it is important to note that lack of funding has created a significant

barrier to effective support. “Clarke” has had experience dealing with various governmental levels:

> Funding, yes, the barrier is provincial. Health Canada has changed the regulations to allow expansion [of iOAT]. That was ten years ago, but the barrier now is at the provincial level of funding.

The whole discussion around the lack of collaborative support for addictions was best summarised by “Clarke’s” views of the Four Pillars approach to addictions that seeks to address harm reduction, enforcement, prevention, and treatment:

> The pillars are not adequately funded. So, there is not a four-pillar approach. It is a four-pillar idea that has not quite been realised.

“Jules” went further in expressing the need for increased examination of funding allocations at the provincial level:

> You know what? Do I think there's money in the system? Oh yeah, we have a $2 billion budget. There is money in the system, but the layers of bureaucracy are always there. We are in healthcare; we are extremely risk averse. We do not want to look bad, and we want to look good, so this plays out that nobody at times can make a decision, even though they know better.

As mentioned in Theme 1, collaboration across sectors was often hindered by competing interests. In particular, police leaders found it difficult to navigate various agency mandates in terms of connecting vulnerable people to supports. “Drew” provided an example for a medium sized BC city:

> I can tell you I have found that in [the city], there were two competing factions within the health industry. There was the health authority that was all about harm reduction, and there was a group of private individual businesses that constructed a facility outside of town. It was all about abstinence, none of this harm reduction stuff. We fed a lot of people into the abstinence path, but also had to manage the health authority’s harm reduction path, right?

“Jules” agreed that competing interests were troubling and went further to describe it as bureaucratising addictions and mental health to protect specific agency agendas:

> We bureaucratise addiction. This is a very strong word, but I am going to use it. We bureaucratise addiction and mental health to a level that is incomparable to other areas in healthcare. So, for example, we have a special ministry and I have to tell you, when I heard about our new Ministry of Mental Health years ago, I said oh no, oh no, another layer of bureaucracy. Bureaucracy. They are the most bureaucratic system.

“Jules’” concern over treating addictions and mental health in a different manner than other health care issues was significant. It spoke to other concerns raised by participants in terms of access to supports and a frustrating siloed approach to carrying out individual agency mandates. Many participants expressed this frustration, but also recognised that there were solutions. For instance, “Avery” recognised that there were issues with the separate mandates and worked to build collaboration:

> Obviously, as we progressed, we started to see major flaws and I guess the way we were doing business it was not great. But now we are working with the social services in the area, and it was great that we were actually trying to bridge a lot of these gaps that we have had forever. We started to see, to realise our own members themselves need advanced training too. The biggest barrier is when you, as a policing agency, believe you only have one little job, and you are not going to work with other people. So, collaboration became probably the number one reason that this worked.

While “Avery” saw barriers removed by recognising that front-line workers could collaborate at their level, police executives agreed on the need for more high-level collaboration, both in terms of decision making and legislation. When asked about this aspect, “Blake” articulated the need for high level steering groups to ensure individual agency mandates do not interfere with each other:

> Stop talking about this as an issue where we have homelessness issue, or a mental health issue, and addiction issue, and we got a committee for this and a committee for that and a committee for this…It is about community safety and well-being. It is about dealing with people in crisis, whatever it is, but they are going to have more than one

> thing going on. They are going to have a lot of different things. Often all three [addiction, mental health, and homelessness], and I often throw in poverty. Throw in, you know, they were abused as a kid. There's childhood trauma and they have got criminal issues as well. You need definitely a holistic approach to these things, right? Do not pigeonhole it. And even in [the health authority] they admit it. And I remember early on in these discussions five or six years ago. You would meet with the addictions doctor and then you would meet with the psychiatrist and they would both give their own view of the world. This guy [doctor] was trying to pull money from this woman [psychiatrist] and this, like vice versa, they were tugging on the same dollar.

One of the critical barriers resulting from the lack of a high-level approach to directing policy and collaboration was the issue around information sharing. Police and medical executives agreed that working together was often hampered by a lack of understanding of privacy legislation. In their view, the wellbeing of an individual or a group superseded legislative restraints on sharing information. As "Blake" explained:

> Partnership and then sharing the data, the information, because it is so intrinsically linked. Its huge, but so there are barriers of the data sharing, but they can be overcome. There's information sharing agreements that have passed the scrutiny of information and privacy commissioners, and they have given their blessing.

"Taylor" agreed:

> We have the [Situation Table] which is a team approach. You know if you can work through the privacy impact assessments and the information sharing, that I think assists in the broader collective approach to deal with the issues. So, I think they did that very well in terms of working through those agreements, and also building the relationships among the different agencies, so that you would have comfort in sharing that information and get a great job on that.

Police executives agreed that the lack of direction with respect to a collaborative, cross sectoral approach was a significant barrier that could be overcome through high level coordination. The concern over information sharing was an example that had been addressed in their view by BC privacy commissioners. The issue was not just between government agencies, but also in the advocacy and support realm. As "Sidney" suggested earlier in this

paper, “everyone knows what needs to be done”. She further stated it was frustrating to have a lack of clear, coordinated direction towards working collaboratively:

> I am really struggling with the direction the board is going. There is some people in your team that, you know, do not buy your philosophy right…and so our board, I think, is taking a more operational approach because I press send on a grant to help with the exploited and trafficked girls, but that is not sexy. They want to serve Caucasian women with black eyes and their arm in a sling. In a pink dress and holding the hand of a child with a teddy bear.

Perceptions of the community were also cited as barriers to a lack of coordinated vision for cross sectoral approaches. A good example of this was presented by “Robin” who expressed the apparent need for retribution in today’s society as opposed to a health centred wellbeing approach. She felt this was especially difficult for police who often bear the brunt of society’s desire to eliminate what are viewed as deviant behaviours:

> I think that the law itself is deeply problematic. I think it is set up this really polarised kind of perceptions on things. I think we have criminalised activities without logical reason behind criminalising them. Instead, we got a fairly moralistic kind of perspective, and we have done it from this perspective of retribution, and these ideas that policing and criminalising people can stop social problems. There is no actual science behind any of that, so I think that the law itself, as the structural frame in which police are forced to work, is one of the really big issues here. I also think there is a really important economics factor. You know if we are having trouble providing resources to people who need those resources, then people are going to turn to illicit means to meet their needs.

Participants in the advocacy group felt the law and perceptions created significant barriers to allowing vulnerable populations to exit from addictions and mental health concerns, either due to the actual law or supporting policy: “Skylar” stated:

> There are so many restrictions and red tape where sometimes it felt exploited even if the intention was not. My managers and supervisors were amazing. So were the social planners at work, but it was really hard when the community has very hard lines on what had to happen and it is all compromised, right?

It was felt that the perceptions of the community drove political response to these social issues, to the point that they did not receive adequate funding. Without the political will to address the issues head on, "Robin" felt the lack of clear goals made it difficult to move forward:

> There is something that the law plays a really important role here in creating barriers to people, but I think part of the other problem here is we do not really know what our goal is. Is our goal peaceful society? I do not know if we all agree that is our goal, you know that would be lovely if we all agree on that. I do not think we are there. I think people keep throwing the word justice around without really thinking about what justice really means to different people.

"Reilly" agreed that without concerted effort and will on the part of government, progress will continue to be slow:

> A huge barrier in meeting our mandate is lack of government will. Even at our most effective, we are still subject to the barriers imposed by law and policy. I think it is very clear around, for example, drug policy and substances. We have been advocating for decriminalisation from the federal government and I think that we are an effective advocate. Our agency is able to really have a strong voice, but if there is no political will?

Perhaps the best explanation of barriers was provided by "Robin", who stated:

> Man, that is where that political, ideological, social aspect of it comes in. Ultimately, this is politics. Your politicians are not going to stand up and say something they do not feel there is support for. Law and order agendas win votes. Hence the system continuing to be the way it is.

Theme Three: Redefining the Role of the Police

Throughout the participant interviews, the definition of the role of the police in addressing the concerns of vulnerable populations was a clear focus. Police executives in particular felt the criminal justice system has been used to ill effect in attempt to address complex social issues best addressed though coordinated pathways to care. Their views were echoed by the other participant groups, all of whom agreed that police have a role in addressing these issues; however, that should be more in a support capacity, except when

criminality is present or public safety is at risk. This theme did not touch on the notion of defunding the police but examined the role of properly funding partner agencies. In the view of the participants, if that meant an eventual stabilisation or decrease in police funding as a result of decreased calls for service, that could be a good long-term result.

Simply reallocating funding from the police in favour of social supports without properly funding those supports was not recognised as an effective strategy. Police executives and frontline officers were quick to point out that they would appreciate being used less for social issues so that they could concentrate on higher level criminal matters. Advocacy participants agreed. “Skylar” put it this way:

> I worry sometimes about the way it is going. Did you want no police? Let me understand this. When you ask a lot of people who do not understand the defund the police movement; what exactly do you mean, that society is well enough and well behaved enough? And that we have the capacity to police ourselves? Because that has never happened, and it never will. I think having those conversations even within my organisation have had some people who are bit too adamant about this. They need to understand in their own personal world what they would need and stop “othering” the people we serve as if they need something different, because their safety is the same.

“Skylar’s” views were indicative of the views of other participants. “Blake’s” experience allowed him to see changes in the approaches to vulnerable populations that are starting to see progress in de-criminalising behaviours by addressing root causes of social issues:

> If you look strictly at what the role of police is, it is the things about preserving life and property, crime prevention, public safety, law enforcement, all the traditional kind of roles. But over the years, what I have seen during my career is that more and more emphasis has been placed on dealing with those upstream drivers that do impact public safety or do impact crime, people in crisis.

“Blake” explained that a significant portion of police time was allocated to dealing with social drivers or what he called upstream drivers of behaviours. Other police executives agreed that

these upstream drivers needed more focus from a collaborative lens, not just by using police response capacities. Much of this was attributed to the deinstitutionalisation of vulnerable people without the necessary community supports:

> We did over-incarcerate or over-institutionalise people with mental health issues. There will always be people that should be institutionalised that are, you know, just a danger to society, like highly violent that you cannot control. But there was more people, probably, in that setting than needed to be. So, the idea of getting them out in the community, and making sure their medication [was used], making sure they were getting supports, mental health professionals meeting with them, all that was good in theory but didn't happen in reality…over the 90's we really saw the number of interactions we were having with people increase dramatically.

"Alex" had a similar experience in his policing career and, in his executive role, expressed his frustrations with the reliance on police to deal with social issues as opposed to the agencies that are better suited:

> I would like to find some better approaches for social disorder in regard to how do we better work with our courts and our justice system with the people who are committing the [low level crime]? We are getting no response. Or the theft from autos who will commit crimes ten times a day to support an addiction. We are not fixing it. So, for me it comes down to the accountability and that is one thing I have been advocating for. We will do everything we can to help you, but at one point when you are not taking that help, there has to be a level of accountability. We rely on external agencies or the criminal justice system to provide that accountability and I would argue, for the minor crimes like that, they do not.

"Blake" expressed the same frustrations in that police were viewed as the easy route to deal with concerns that were better suited to other agencies:

> So, nobody was prepared to deal with it [mental health]. The health system was overwhelmed with that, so consequently we get calls when those people, in some cases, commit crime, or if they become suicidal, or they are yelling or screaming in the street, or having an episode, or people just are not sure what to do. We have somebody in our business who will not leave. There is somebody strange walking down the street. I am not sure what they are up to. You get all these suspicious person or suspicious circumstance type calls, you name it. Just so many things that will come across the radar of police that we respond to…and that burden becomes very heavy on police, not just here but in Canada.

The expectation that police will respond to issues clearly related to addictions or mental health has, in the view of police leaders, become mainstream. Since there are insufficient supports for vulnerable populations, “Taylor” argued that police had no choice but to respond, even if they are not fully equipped or the appropriate agency:

> Like I said before, it is very difficult to disengage, and at some point, particularly with mental health, if you can't secure a voluntary apprehension…if you can't deescalate the situation and secure a voluntary apprehension, there is going to be a physical confrontation at some point…. It can escalate incredibly quickly, right? By virtue of the nature of all the gear that we carry now for protecting everybody, whether it is carbines, or Tasers, or firearms, or batons, or pepper spray, they are going to be used at some point if the threat level escalates. That is the training, that is the response; and that really presents the challenge. So, the more focus we can have on de-escalation, and avoiding unless absolutely necessary, any use of force, I think the better off we are in dealing with those situations.

Police leaders recognised that they had a role with respect to dealing with persons suffering from addictions and those with mental health concerns since other agencies were not equipped or did not have the capacity to intervene. Instead of police-only responses, “Drew” explained that partnerships and structural change were needed to share the load with the most appropriate agency:

> Because as I said, we always have that space for police when you are dealing with these people, like this sector, these vulnerable people. So, to have someone dedicated to doing that is important, but not just one person on a [police] watch, that will easily get consumed and cannot keep up. If you have a huge chunk and I just made up those numbers 75/25, maybe it is 50/50, maybe it is 90/10, I do not know, but whatever that complement is that can address that community’s issues because some are worse than others. So, I think those alternatives in terms of significant structural change to how the government approaches the vulnerable people needs to occur, and the structure of how policing is delivered needs to follow that investment.

The experience on the front-line is reflective of the concerns of police leaders. Previous direction to enforce all manner of offences has given way to seeking collaboration and support,

although the change has been slow to materialize across sectors. “Avery” has seen the change firsthand:

> I have seen everything. I have gone from an enforcement background where it was enforcing every single little thing. You know, the more people you take to cells, the better, but I saw how that failed. How pitiful that was of a strategy. Obviously, I did that. I spent about five years just on [the street] dealing with the drug dealers, dealing with people that were addicted, dealing with the social services down there. There was no ability, and no time to collaborate. It just was not even in the cards at that time. It was enforcement, enforcement, enforcement. It was about stats and it was about putting people in jail. That is what management wanted from us. That is what they thought would bring down the complaints in the area, and that is what we did.

Although police have steadily changed their approach from enforcement-only strategies to collaborative effort, it remains a difficult task. Police are not particularly well suited to be everything for everyone in the community. “Robin” explained the difficulty faced by police in trying to protect vulnerable populations while enforcing societal expectations:

> I cannot imagine just how difficult it is for police in that role because you are given both the protection and prosecution mandate. This is one of my issues that I always brought up in the context of the sex industry. You are given both. You are supposed to somehow both protect but also prosecute. You just cannot do both. So, for some people, as soon as you move more into that prosecution side, you will never again be able to protect that person.

“Reilly” also suggested that perceptions play a large role in what society considers as significant crime or social issues. She further explained that police need to be part of the conversation to identify the important issues and approaches:

> To some degree police contribute to the moral panic that is out there…We live in communities that are on balance, quite safe. Violent crime rates have dropped. But people’s bikes get stolen and like, that is a huge thing. People take cycling very seriously, but the level of the kind of outrage that the police would generate off of these things, which are property crimes, and I am not saying it's fun to get your things stolen, but we have to be able to nuance this. So, we have the police kind of talking about stolen bikes, and fake guns, and people sitting underneath awnings, that become the focus… I am not saying I want a world where people are getting hurt, but I also think we have to be able

> to understand that a bike being stolen is different than a predatory serial killer in our community…but I see the police really feeding in to, like a bit of mania.

"Reilly's" observations are relevant to police perceptions. Police executives stated they wanted to change their focus to more serious calls for service with a view towards increasing wellbeing for everyone, including vulnerable populations. "Blake" was encouraged by an increasing understanding of root causes by police and health professionals:

> We are public safety and law enforcement experts. So, we want to work with you guys [health industry]. And if you are telling us that this is a good conduit to save people's lives and make a difference, then fine. We agreed to the Health Canada exemption because they needed our sign off back in 2003… so our officers actually will direct people, like if they see somebody shooting up in a laneway, they will direct them. 'Hey man, use the supervised consumption site down the road, there's nurses there and they will make sure you don't overdose and get you help.' They direct a lot of people there. When it first started 17 years ago it was hard for us because of that generation of police up to that point.

Police participants stated they believed they should be targeting the criminal element of the drug trade, as opposed to the victims thereof; in this case, the marginalised people they were trying to protect. "Avery" was quite clear on the approach his team adopted in his large urban jurisdiction:

> You are bringing in fentanyl into my community? Absolutely, I think we should throw the book at you, right? But for somebody that is using, I mean, come on. Let us just come up with a better strategy for how we are going to get that person healthy again. It is not about throwing them in jail, I can tell you that much. It was all about concentrating on who is dealing, but I started really looking at it from a broader perspective. Dealing with that population and just hammering them and having this myopic, microscopic, myopic kind of view of dealing with it, just dealing with it as a police officer and not looking at the broader picture. So, I rewrote the entire thing, and I came up with a team that would actually be out there to assist.

Police participants, especially executives, understood the futility of targeting at the wrong level. "Drew" felt police efforts should focus on interdicting high-level traffickers, while realising that the issue will continue without a different approach:

> We find whenever you disrupt drug groups, it feels good because we are stopping the distribution of that drug, but what it also does is create marketspace, right? Then often conflict for that marketspace, because there is always somebody to come in behind to fill that marketplace. That is why the war on drugs can never be won, because there is always somebody to come in behind when you disrupt and dismantle. I am not saying we cannot do it or should not do it, but that's our conundrum.

From a medical perspective, the trauma that causes many in the vulnerable population to fall into addictions was viewed as exploited by traffickers. Medical professionals acknowledged the police's role in interdicting illicit supply in addition to treatment. "Charlie" put it this way:

> I think the police really need to be focusing on enforcement and getting to individuals and groups that are running the drugs into the area. They are the people creating the power structure that keeps people under their thumb. So, I think that enforcement element is important. I think they need to be supportive of redirecting people that are the users, if you want to put it that way, into treatment. I know there is perhaps a fine line sometimes there, but yeah, generally I think the focus needs to be on the dealers and dealing with these rings and so forth.

From a mental health perspective, participants agreed that collaboration needed to increase to refocus police from the primary role of mental health response. Again, they emphasised that police need not be fully removed, but placed in a support role. Much of this stemmed from an inability to share information in a timely manner to eliminate redundancy of action. As "Blake" pointed out:

> We have got all these people that do not need to be institutionalised, but we are having a lot of calls for service for them, so we set up a program where we track them through PRIME[5]. So, we look at these people and we have an early warning system where we pull the data out of RMS[6] and we put a note on CAD[7] and we say okay, here is the people that we are dealing with on a regular basis, like high incidents of police involvement. Let us get an information sharing agreement going with health, because health is dealing with these same people every time, we are picking somebody up and

[5] Police Records and Information Environment – The police dispatch and report generation system in BC.
[6] Records Management System – Directly linked to PRIME.
[7] Computer Aided Dispatch – Directly linked to PRIME.

> for whatever reason we take him hospital. They know these people on a first name basis. We got an information sharing agreement that went through the Privacy Commissioner and everything. We can view health records and they [health] can view police records for public safety purposes under the Police Act. We meet every single day in this program.

The development of partnerships was viewed as key to success in moving people out of a street entrenched lifestyle and into support. “Blake” and “Alex” emphasised the importance of dedicated police positions that can work with vulnerable populations and outreach teams. “Blake” stated:

> There is a lot more that can be done to support, but we do have people dedicated. One constable right now is a full-time homeless outreach coordinator. But then you are going to get into this argument, why are the police even in that space? Why are you there? Why aren't they out catching bank robbers? But we have come to realise that our officers are dealing with people living in alcoves, in doorways and parks, and those people need a path sometimes. That officer is very good at getting the path to housing, and that sort of thing.

Alex agreed with the need for outreach:

> So, the street outreach response team is working with our homeless community, working with our partners, to get people into pathways of care and getting them connected. We have a project, kind of like bar watch, where businesses can sign up for this program and then they give us the authority under the Trespass Act to remove people from their alcoves and doorways. It was a huge problem of people defecating, using alcoves as their home, and causing issues. So now our police officers will go by the businesses and not just kick them away and tell them you got to move on but identify the person. Then they are connecting with someone from our street outreach response team who will then connect them to care and support.

Participants recognised that the role of police with respect to public safety was not just about the community, but the need to support outreach workers as well. They stated it was difficult to separate the role of police from the role of these programs because they were so intrinsically linked. They advised that the vulnerable populations were often victimised and the areas they lived in could be unsafe without police support. “Taylor” stated:

> Persons that were struggling with addictions, not just drug addictions, but you know multiple issues, mental health issues and homelessness at that point in time. We had upwards of 200 campers that brought all kinds of social disorder. It was our highest concentrated area for property crimes, violent crime, physical assaults, robberies. You know, drug trafficking, sex trade, assault on sex trade workers, you name it. It sucked in a considerable amount of police resources, not just from the enforcement perspective to deal with and respond to all the criminal complaints that came out of it, but to protect the area.

"Alex" agreed with the need for police in certain situations but was also supportive of agencies responding on their own if there was no indication of the danger referred to by "Taylor":

> And for those calls where we do not think there is a danger to the public or the individual, they [outreach] can attend. Even just a month ago I heard a call of an elderly male walking down the road who was wearing a hospital gown and appeared to be mentally unstable. Well, I will argue we do not need to send police officers in bulletproof vests and a gun to that call, and I would have loved to have been able to send him into health care with no police officer.

"Alex's" observations presented the need for new approaches to dealing with social disorder and police response. Participants agreed that these approaches needed to focus on increased outreach in terms of training and partnership that allowed police to support other agencies. "Taylor" explained that programs needed to be developed that removed police from primary response:

> But at its core, it is not a crime issue, but it can bleed into a public safety issue. I look at it more of a health and social issue that the police, through the absence of engagement of other agencies and bodies, are left to deal with or kind of clean up. I think when that happens then police start to assume roles that go far beyond their regular role in law enforcement.

Frontline police officers were willing to engage in the collaborative effort to move police back toward their primary duties, while working towards collaborative solutions. "Jordan" was engaged with vulnerable populations every day:

> When I first started it was because of the missing women background. Coming downtown I needed to be sort of part of the community. You need to be in the

> community. A lot of their stuff is court related. But the work that I do is different, you know? My approach is different because I am allowed to do that. When I first started realising that I was really blurring the lines here, but I am police first. I told my boss that I guaranteed two things. I am not going to do anything to get myself fired, and I'm not going to do anything to embarrass the department. For the rest you give me a full tank of gas. There is just so much more that we can do.

Similarly, "Avery" emphasised the need to engage directly with the population with compassion and understanding:

> Understanding the empathy that you really need to start to work with these individuals is kind of where were we went. It was strange because you got this, I want to call it a motley crew of young officers that just kind of came to me. You know, I had a few volunteers. They were excited, they wanted to go out there and do that work. But then I had a whole bunch that just did not want to be there. You know they first came in; they were like, what are we doing? We are going to hammer these guys and put them in jail, and I am going to go find every warrant. What we actually needed to do was to work in established relationships with our partners and we cannot be looking like we are over heavy handed. So, there was a huge education component that had to be every single time I had a new person come to the unit. We had to educate them that this is not about hammering somebody.

"Avery's" compassionate and understanding approach was echoed by advocacy participants who emphasised the need to understand why vulnerable populations found themselves in their circumstance at the root level. Developing trauma informed responses was a key recommendation from "Robin":

> You know people were in desperate circumstances who are now in more desperate circumstances, but I think at the same time you have these incredible politics [defund the police] that rose last summer…. what does it look like for police to reallocate resources, what can we realistically expect police to do? Where have we gone too far in kind of turning police officers into social workers? So, I think it has been an interesting journey for me from working from the trauma of the community at the time to working with police, trying to heal some of those pieces and try to make some of those pieces better…it was the first time that we saw police departments coming to the table and saying we need to do things differently. What we have been doing is not working, so even if it was not full agreement, but there were segments of agreement and there was a common desire.

Theme Four: Investment and Resources

The need for further investment and resources was identified by all participants as key to providing support for vulnerable populations, not just in terms of addictions and mental health treatment, but for overall wellbeing. There was consensus among the participants that under-resourcing, deinstitutionalisation, and lack of in-community supports has led to the current homelessness crisis and stigmatisation of vulnerable populations.

Participants felt that several sectors required significant substantive investment, not simply a reallocation of funding from one sector to the other. While this may be possible in the long-term, most participants, particularly police, feared that reallocation of funding without addressing the upstream behavioural drivers would cause a negative impact to public safety and wellbeing.

Police executives feared that response-based workload would still remain in their mandate if other agencies were incapable of providing around the clock service. Their fears appeared to be well founded based on the downloading of services over the past several decades from institutionalised settings to community-based services. At issue was the belief that these community-based services did not have the resources or capacity to address the complex needs of the vulnerable populations, so this was left to emergency services to deal with. “Blake” explained it as follows:

> They are victims. There has been a huge downloading over the years onto police who were dealing with it more and more. It started probably with the de-institutionalisation back in the late 80s, early 90s. It was not just a [city], or BC, or even a Canadian thing. It was the whole western world. It was sort of the philosophy at that time of day, de-institutionalising people, which makes sense if you have the right supports in place. They think, probably, in the Western world we did over-incarcerate or over institutionalise people that had mental health issues.

Advocacy participants expressed concern with society's lack of understanding of the root causes of additions and mental health that created an acceptance of criminal justice approaches. "Skylar" stated:

> You are painting everybody with the same brush. When [a vulnerable person] says I am having a mental breakdown or anything like that, they do not need to see units come with guns, but there is no one else to call, and maybe at least somebody will keep me safe. They say to me, yeah, I am traumatised by it…This is the thing that I have been on the phone with them when I was in housing, and it's not their fault, it's the resources.

"Reilly" expressed the concern that the criminal justice system was not only the wrong system to deal with social disorder, but that this issue went deeper into the very structure of our justice system:

> Not just human rights codes, but a real recognition that we are often having to shoehorn deeply complex social, economic, intergenerational issues into the very narrow framework of legitimacy of a court. We are forcing people through a process that can at best be ineffectual, at worst can further traumatise them. So now we are looking at tools like communications, shifting public narratives through media, police, and also just trying to focus our work on the most impacted communities.

"Reilly's" concerns were echoed by "Sidney" who saw a revolving door approach, centred on the criminal justice system instead of root causes and actual trauma. In this example, she was describing intimate partner violence and the propensity to separate children from struggling parents:

> And if it's criminal or child protection related, some of them are just so sad. And you know, [a woman] fought back but…. they have been charged. Then with the child protection, all of their children have been apprehended, but what are the ages? Zero to five, 6 to 12, and 8 to 13? I mean, in just a very small sector, 14 children have been apprehended. First Nations children like that, so 14 lives have been just torn apart anyway, so there is a lot of work that needs to be done in building capacity in our services.

Considering that a large proportion of vulnerable populations have struggles with ACEs and other trauma, “Robin” expressed the need for more resources in that sector that created the conditions for better success in adulthood:

> As an alternative, how about we do not cause the problems in the first place. If you think about our childcare systems, you will think that the support for families exists, particularly those of lower socio-economics. One of the hugest, most important risk factors for youth is whether they have ever been in care. If you have been in care with the government, then that means you are like 10 times more likely to actually be victimised, have addiction, and end up homeless. That is the government care. That is on us, right? That is on us.

“Skylar” agreed:

> But what if somebody could actually respond with the skill and medical expertise? But I know there is a lack of that response because even if they expressed it, where do we put him? Where do we take him? What do we take on? So, you cannot just look at just the police without separately looking at the systems that need so much done…. mental health treatment is absolutely crime prevention. It straight up makes sense, and it is not new, it is just the system again.

From a medical perspective, “Clarke” and “Charlie” saw the lack of resources as particularly troubling when trying to treat addicted people. In their view, the overuse of the criminal justice system was borne out in the lack of access to other supports. Clarke explained:

> And when people started at our clinic, 80% had unstable housing within the last two years. 80% had no primary care provider or a formal connection with the health care system and most of the 80% had been in jail for at least a month. So, they have better connection with the criminal justice system than they do with the health care system, right?

“Charlie’ described the lack of resources as a failure in the system. He stated that there were insufficient access points, so people found themselves on the street with nowhere to go:

> Those numbers began to grow over the years, and I would see more and more mentally ill people, people that needed treatment. But the system was failing them in just pushing them out. And these promised services were not there, they were not. There was no safety net, and gradually those people were turning to street drugs as well to manage. They did not want their loud noises in their head, and they did not want the

> drugs that mental health was giving them so they would start using other drugs. We started to see more momentum grow with that and I think that was a huge shift.

"Clarke" expanded on the issue by addressing the need for additional services, including collaboration at all points in the system, and within his mandate, opioid agonist treatment:

> So, we need to provide comprehensive care and comprehensive services, and I guess why I'm telling you that? Because the system does not, does not, meet people where they are at and provide those services that are required. At this point that is something we aspire to, but we are not quite there as a clinic, or as a health authority yet. We see a clientele who have not been engaged prior to having access to the program that we offer. That includes substance use, and unmet needs, and in general, health and mental health. All those, all those domains improve when people have access to this service.

The need for medical and social support was amplified by "Alex", who, as a police leader, was concerned with the number of resources his department had to expend in this sector:

> I am frustrated that I actually have four police officers fully engaged, and that is actually small, between homelessness and addictions. I really think that is more of a health authority issue. Health should be taking the lead on that, so I am frustrated when I phone, you know, the CEO of [the health authority] and plead for resourcing for people to take a lead, I just do not get the response that I would hope for. Unfortunately, I think with the police, that we are part of the problem, right? Like, we solve problems, we get the job done and unfortunately that is why we end up managing it in regard to social disorder.

A common concern expressed by participants was the lack of alternatives to police attendance. "Skylar's' experience was that emergency services were left as the only response to complex issues due to the narrow framework of emergent and non-emergent call response, thus creating redundancy:

> At 3:00 o'clock in the morning who are you calling? And this is a thing when it comes to resources. One thing we have thought about is 911. There's non-emergency and there's emergency [call centres] right now in Vancouver and then you usually have to wait before you are asked if you want fire, police, or ambulance. Often, you expect the paramedics to come, but then you have the police behind you, and fire. It is understanding who needs to be responding.

“Blake” experienced similar frustration but stated they were starting to see increased collaboration, which was good in his view, but not sufficient in terms of the actual resources needed:

> And it is really sort of highlighting the fact that there are all these gaps in the system which started more conversations happening here in the city. It is a lot better now. It is not perfect, but we have a lot of things now that we did not have before. We have got mobile overdose outreach teams where we have got social workers and [health authority] people. Nurses are out on the street and they can get people moved into different treatment options. We got it in our jail now. Some people come in and the jail actually does a really good job of triaging people. We've got doctors and nurses that work there full time. There are always at least two nurses on duty, and we have a doctor that comes in every day.

Police executives agreed that while investment is needed, there was good work being done at the local level to set parameters for increased funding and to encourage collaboration. For instance, there was increased understanding by health authorities of the need to allow hospitals to support vulnerable populations, regardless of how they enter the system. From the front-line officer’s perspective, without this type of increased collaboration, the lack of resources was not only frustrating, but heartbreaking as they sought to bring supports to vulnerable people. “Kennedy” pointed out the human toll:

> It is, I mean, it is sad because a lot of the people that come up to the car and they are like, hey, I am ready. I need to get clean now. I have to literally tell them okay, let us make a phone call, and you will be on a wait list for a month for you to get to [treatment]. Even then it is only one week for heroin, fentanyl, cocaine addictions, and meth, and then two weeks for alcohol. That is not fair. You are going to kick a person that's two weeks clean and sober back onto the street? You are 100% going to put that person in that same situation. They are going to die.

“Charlie” summed up the unintended consequence of deinstitutionalisation from not putting the necessary infrastructure into the community in the first place. His concern was that without proper support, too many people have fallen though the systemic cracks:

> You will pay a price down the road. That is great, and it is all well and good to decentralise places. The government at that time had decided to quickly move from a centralised approach of providing centralised care for the most severely mentally ill, vulnerable individuals, and instead they were going to decentralise the money and put it into the local communities. There was a promise that all of the money would be in the local community to support the individuals that needed at the most. I would be sitting up in my office and I began to look out my window and see walking through the parking lot somebody that obviously should have been in a mental health boarding home. I could see that they were psychotic, untreated, no support, no outreach there to help them. Obviously, the system had already failed.

The trend towards deinstitutionalisation without effective community supports was seen by police executives as a significant driver in their current workload. Just as "Charlie" articulated, police leaders felt the closure of institutions, such as Riverview in BC, led to a marked surge in vulnerable people in the community without adequate support. While they recognised the need to be part of supporting those populations, they were unanimously concerned that police responses created potential dangers of escalation, including use of force, to a population that would be better supported through medical or event co-responder intervention. They referred to the current approach as a "band-aid" solution to the required investment that should include increased medical and treatment support, especially in smaller communities. Emphasis on de-escalation, improved access to pathways of care, and increased overall training were all viewed as important steps towards community wellbeing. Their unanimous concern was that although they viewed the situation as improving, there was still not enough access to treatment and support, such as housing or social assistance. "Jordan" agreed with the earlier comments by "Kennedy" that without ongoing and dedicated support, people trying to recover would just regress:

> Let's stop along the way so you can heal. You do not just go back out on the street. A lot of people end up going to detox. They leave after four or five days and then they just

> come back on the street. It is just like that is their break, right? Just kind of taking their January dry month but taking it in three days and then just going right back again.

The needs of the vulnerable populations were expressed by advocacy and medical participants as very complex. They agreed that stigmatisation led to a view that certain people were "lesser than" the rest of the population and, as such, government was less willing to support them. "Robin" expressed the need to place more emphasis on root causes:

> People really, really, really need to remember some of the causes of addiction, and that we are very often dealing with trauma, and addiction as a response to trauma. It is a way for people to escape trauma, and then it often leads to more trauma, which they then need to escape the secondary trauma. So, I think that the only way that you honestly have people moving forward, who are already dealing with really hardcore addictions, is to treat. So, it cannot just be that we are going to provide you with that service, it has to also be housing that has to also be such intensive support. That is going to be much more expensive.

"Charlie" agreed:

> It is the same attitude, I think. It is the same pervasive attitude. We know it is there, but we do not want to do anything about it and do not want to put the money. And now we are throwing money, perhaps at it, and it has become a tsunami. There is a huge correlation between mental health and addiction. I think the research shows that quite clearly. Homelessness becomes a sort of an outgrowth of it. As the person's lifestyle and capabilities deteriorate, they lose. They go through a series of losses and lose the support networks they have.

This observation was echoed by police executives who were concerned by the haphazard approach to dealing with homeless populations who usually fall into vulnerable categories. They felt that a criminal justice approach involving police as enforcers was misguided and dangerous, even though it has been used to dismantle unsightly camps. "Blake" considered the approach of moving people around without investing in long term supports as futile:

> Over 90% of those people had mental health issues and over 90% were addicted. You may have a few people in there that are one or the other, but almost everybody is both. So, you have taken 170 people that are living in a park in the [downtown] and have now moved them over to a [different park] or put them in a building. Then we have

> politicians celebrating it because we have given them a roof over the head. That is great. That is perfect, but you have done about 1/3 of what you need to do…They are still going to be anti-social. They are unable in many cases to function in society. They are still committing crime to support their habits. There is still going to be wandering the streets accosting people, breaking into cars. Where is the plan for all that right? There is none. What is that pathway to care? What is the plan? Yeah, very good question that that seems to be asked a lot, but that answer is not forthcoming.

Advocacy participants supported the police assertion that there were not enough support plans in place, which were exacerbated by ineffective policies. "Reilly" previously pointed out that current laws were actually detrimental to supporting some vulnerable populations and expanded on that observation:

> We also have some key events in the law around rights of people to shelter in public parks. The recognition that displacing them is an inequitable solution, that it disproportionately harms indigenous people, and people with disabilities. In some ways those are wins right there. But then we also see on the flipside, the reaction that happens in municipalities because that is where a lot of bylaws are actually enforced. It really feels like whack a mole and I think that courts cannot really address that, and also going through litigation is such an expensive, resource intensive process. Those resources, both from our agency, but also from government, could be better utilised actually just providing the things people need.

Participants agreed there were positive steps being made, but the need for an overall plan was urgently required, one which was not compartmentalised by government, but involved all sectors working together. They all agreed that preventative measures, as opposed to the current reactive structure, were needed not just to reduce police calls for service, but to prevent repeated medical calls for people who should have substantive support. There were examples of effective support in large cities that involved investment and collaboration between police and health, but also other social support services. "Blake" talked about community outreach partnerships, such as ACT and assertive outreach, as opposed to reactive only models:

> There is a cohort of about 400 people in the city that we deal with. We have reduced police calls for service with that cohort by over 50%, and hospital visits by over 60%. You think policing is expensive, healthcare is even more expensive, so it does work. The proactive side. I just really want to get people away from this car 87 or 67, whatever you call it. It is great, but it is not the answer, it is the proactive side. You got to go to upstream and help people get on a better track.

Police executives also spoke about the apparent decreases in 2020 of crime types typically associated to vulnerable populations due to the supports they received during the COVID-19 pandemic. They reasoned that housing a large portion of the vulnerable population and giving them increased funding reduced the incentive to commit crime. Even if increased funding from the Canada Emergency Response Benefit (CERB) was used to support addiction needs, it had the benefit of reducing crime. “Alex” stated:

> We started tracking when CERB came in, what our property crime levels were, and we saw for that five months, as CERB was in place, our property crime levels for that entire five months actually went down. So, I think CERB was an unbelievably amazing social experiment, because it actually showed that when individuals received additional funding and things, there was a significant reduction in property crime. Now there are other things in play of course. More people were at home so less break ins, but we do need to study that and learn from that.

A continuum of support was emphasised by all participants. They felt that simply treating one aspect of need fell short of the overall support required to address the complex interconnection between addictions, mental health, poverty, and homelessness, especially as it related to trauma. All participants agreed that housing was essential to stabilise vulnerable populations as a precursor to further effective supports. The discussions often centered around access points to care, regardless of which agency was primary. “Jules” expressed the need for increased connection between the medical and social support sectors:

> Many times, there is no housing available, so we have to discharge to their preadmission situation. Sometimes it is a hotel. Sometimes we can link them to BC

> housing or other housing, but it is a large wait list. It is not like people in acute care or needing medical get preferential treatment…There are times where we have to have people who happen to be homeless come into our outpatient clinic, which is a whole other issue to actually get the treatment they need.

Participants considered where the funding could come from. While they agreed there needed to be substantive funding put in place, they also realised that collaboration could create the conditions to allow reallocation of funding or simply better efficiency. “Jules” put it this way:

> So, I am going to tell you something that's fairly provocative. We are not underfunded. We have misaligned our resources in ways that do not serve the citizens that need the services the most. I do not believe, and I am going into 30 years of my health care career, I do not believe we are underfunded. I think we have so many triplicate and quadruplicate layers and layers in our system.

Overall, participants agreed that funding and political will were the main drivers for successful outcomes. They submitted that effective solutions in providing pathways to care would be expensive, but felt that, even in the near term, the overall cost would be reduced, especially with regard to police response and emergency medical interventions. Effective collaborations that were underway were also recommended for immediate support. For instance, the iOAT programs in Vancouver only reached a fraction of the people who could benefit from that treatment program. According to “Clarke”:

> For the small number of people that are here, yeah, we are doing great. But for the people that are out in the street and do not have access to the services that are needed, it is a public health disaster.

Participants agreed that part of the issue was a lack of political will, complicated by a bureaucracy that was lethargic in its approach to vulnerable populations. As “Robin” stated:

> Society is not going to support politicians or others who come forward as champions of those groups. So, we have a really fundamental problem here, and that is even if you have people sitting around the room with power to make these choices, you have rejection from communities. You would need to approach things from so many different directions at exactly the same time. There is an educational piece here that is so vitally

> important. There is a whole re jigging of a criminal justice system. It is not just police, and it drives me nuts when I see these conversations stop at police services. We forget that actually they are just the front of the system, and the system is huge….so just deciding okay we are going to reallocate some of the policing funding, or we are not going to hire more police, or we are going to put money towards partnership with social workers. Okay, cool, but what about when somebody is affecting crime? And who is who is assisting that person through the process?

"Charlie" agreed:

> I think up to the present time there has been a collective lack of will by policymakers and not an absence or ignorance of the problems. We are not lacking a lot of knowledge or understanding or even statistics. So today there are a number of really useful services available, both by government funding and by non-profit sector funding, but their funding and their ability to stay afloat is so tenuous because of budget changes, they are the first organisations and services that get cut. As a result, the continuity of care is lost, which is critical in managing people with mental health or addictive problems… It comes down to finances and political will and unfortunately that boils down to what will get me re-elected.

Theme Five: Understanding Trauma and Reducing Stigma

Participants in this study were very concerned about the lack of resources dedicated to vulnerable populations that they felt was due to the stigma associated to these groups. They were unanimous in their view that vulnerable populations, especially those experiencing homelessness, were more likely to be criminalised by the community than they were to be seen as needing support. Societal attitudes, fueled by Canadian drug policy and moral panic, were viewed not only as barriers to effective reform and support, but as stigmatising principles preventing that support that was manifested in the lack of political will and funding. As "Clarke" put it:

> Well, the fact that it's not funded is stigma. So, it sounds like a catch 22. The stigma is at the funding level. The stigma is at the cabinet level in the province.

A lack of understanding of the trauma experienced by vulnerable populations was also viewed by all participants, regardless of background, as a barrier to reducing stigma. All

participants felt that increased education was required for BC and Canadian communities in general to understand what caused people to move into a vulnerable state. Much of this was attributed to deinstitutionalisation that brought the hidden magnitude of the problem to the forefront. As “Charlie” observed:

> And the system began to breakdown at that level and that dates back to the mid 90s. Over that period of time, the number of homeless and mentally ill grew exponentially. There was no safety net. They had been promised the money, but it was not put back into the community to create boarding homes and create mental health outreach teams that would go into the community and find these people and work with them. They just weren't there, so we ended up with people fending for themselves. Oftentimes the police would be down in the parking lot dealing with a mentally ill individual, who probably could have been managed, and treated, and lived a much more functional life, but now they were getting connected into the criminal justice system…I could see the trend of what was happening and that's continued on. And now of course with the drug issues as well.

Participants felt that stigmatisation caused society to be more comfortable with using criminal justice approaches since they felt vulnerable people were responsible for the majority of social disorder in their communities. Participants attributed this to a lack of understanding of what vulnerable populations were experiencing. In many cases, participants believed these populations were looked down upon, as opposed to being considered as candidates for support. Robin put it succinctly:

> The same person can also be seen as a victim on one corner of the street, right? And then they walk to the other corner and are perceived as an offender. That comes out when we think about who a deserving victim is and who is not a deserving victim… It is very strange, but we do have these ideas behind us about deserving and they play out in really specific political socio-economic ways. So, these are all way bigger than any individual police officer or even individual police department. And they make it virtually impossible, and they create these tremendous barriers because we can never actually get on the same page in the first place.

“Skylar” agreed that community perceptions actively contribute to stigma, due to a lack of understanding of trauma:

> A lot of people are really willing to do that, you know, say you just got to pull your boots up or pull your bootstraps up, right? Or I'll give people money if they're going to change their life. I will fund something like that if they're going to turn their life around and become taxpayers, but if they are not, I am not interested…. If it hits anybody mainstream, or if it threatens certain people's lives, the money will be spent...

Other participants from the advocacy sector felt the issue centred around unfair policies and practices that put people in a no-win situation. They cited the court system as particularly prone to further victimising or traumatising vulnerable peoples, as well as the health system that was not easily accessible. They agreed that the lack of government support and downloading exacerbated the lack of accessibility. For instance, they cited the propensity of various governmental levels to consider complex issues, like crime, housing, or addictions as singular problems when they should be viewed as interconnected. In particular, municipalities were cited as not wanting to be seen as soft on crime, which caused them to implement policies that were marginalising to the most vulnerable people. "Reilly" felt that this led to increased stigmatisation:

> There is a huge issue around stigma and what constitutes a vulnerable population. People are made vulnerable by poor policy, by lack of access to resources, due to stigmatising beliefs, and prejudice around the activities they do in their life. I'm not really sure if the courts are able to address that…the *Mental Health Act* also contains a lot of provisions where people lose their autonomy when they're certified, so it's not necessarily something that keeps people safe. It's just not. It's another different type of control.

Further blurring the line between criminality and victimisation was the public view that these populations committed the majority of crime, despite evidence to the contrary. Police executives and front-line officers agreed that was not the reality and that more serious crime was committed by relatively few prolific offenders. They refuted claims that vulnerable populations were crime drivers stating that the majority of crime committed by vulnerable

populations was on the lower end of the scale, particularly nuisance or minor property crime. On the other hand, vulnerable populations were highly victimised by predators who took advantage of them. These observations were backed up by statistics, but "Blake" also attributed societal perceptions to a type of stigma:

> People focus on people that may be addicted or mentally ill. That they are bad people, or they are committing crime. And yes, that does happen and there is that whole life cycle of addiction with committing petty crime to support your addiction and that goes round and round, breaking into cars and stuff. But the other thing we have done quite a bit of research on is the victimisation patterns of people that are suffering from mental health and addiction issues. You are 15 times more likely to be the victim of a crime if you are suffering from mental health issues. 23 times more likely to be the victim of violent crime, and 19 times more likely to be the victim of crime if you are homeless.

Police executives agreed that this type of stigmatisation was challenging in creating approaches to support these populations and to generate collaborative efforts. They were troubled that the lack of resources and funding delegated to these issues continued to force agencies to work in siloes that only served to exacerbate the stigmatisation of the population by increasing the complexity of their access to care. "Blake" expressed concern that first access to care was often generated through an introduction to the criminal justice system, as opposed to addressing the health and poverty issues of the person in the first instance. "Drew" agreed that the propensity to criminalise first and support after was problematic:

> The mayor there is very concerned about the homelessness issue and wants them eliminated from the downtown core. He says they are homelessness issues, but he knows that chances are there are some other issues involved with that homeless person. There are some addictions potentially on board with that person. Some mental illness potentially, or other issues that are unknown. You know, trauma in their lives. But generally, it's just that "Get them off the street" request.

"Drew" expanded on this desire to address the unsightliness of homelessness as opposed to the root cause:

> They're just aesthetically not pleasing, and we get calls because they're unsightly. Mayors and city managers want them out because they're not aesthetically pleasing but they are not really committing any crime.

The desire to only address specific symptoms can actually contribute to stigmatisation by creating a type of circuit breaker approach to vulnerable populations. Instead of addressing root causes, communities often default to enforcement since it appears easier and more expedient. In “Taylor’s” experience:

> If they want assistance, you know they are going to call for the police. It may be presented as a criminal related call, but in reality, it's not…it is trying to find that balance of the homelessness issue, but also creating some structure around society’s expectations on victimisation, crime, drug use and the like. Sometimes, unfortunately, those homeless camps are subject to being victimised by drug traffickers and the like because they know that there is a very significant client base.

The importance of outreach and building relationships with vulnerable populations was seen by police participants and advocacy groups as a key component of reducing stigmatisation. They argued that treating these populations with dignity and respect would go further in building community wellness than enforcement and stigmatisation. “Avery” had first had experience with the trauma experienced by homeless individuals, and cited approaches that started to restore dignity and wellness:

> We had people living in tents and they freeze to the ground. They literally freeze to the ground. You know there was one washroom for 200 people, and it was an outhouse. It was disgusting. How is that Canadian?...you need to be a little bit gentle and deal with people that are dealing with some of the most difficult situations that any human being can be going through. Poverty, extreme poverty, extreme addiction, not knowing where you are going to get your next meal, like these types of things…. and then if you spend a little bit of time with somebody, yeah, they might call you a pig, but after about three weeks and you are talking to him every day, and they actually have a big smile on their face when you come up to talk to them. They realise you are not there to put them in jail. You are just there to make sure they are safe.

There was consensus among all participants that root causes stemming from trauma, ACEs, and marginalisation contributed to stigma around vulnerable populations. They articulated the need to understand individual circumstances and develop approaches that did not demand a certain level of success to enter a program, but more of a "meet them where they are" approach. "Sidney" stated:

> We have to understand that there are different lenses. There is a cultural lens. There is a gendered lens that we have to bring to it, and we have to provide opportunities for all people.

In this regard, police executives agreed that a one size fits all approach would not be effective. They agreed with advocacy participants that the individual circumstances of a vulnerable person needed to be taken into account in everything from restorative justice to court and sentencing. Acknowledging the history of the individual was viewed as vital to developing supports for that individual. While this approach once again emphasised the need for additional resources, it also focused on the restoration of dignity. "Alex" further explained:

> So, I would like to see a preventative approach where we are able to identify those that we know are very susceptible because of trauma and provide them more supports to not go down that pathway in the first place.

The recognition by police executives for the need to understand individual circumstance would appear to have been transmitted well to the front-line. "Kennedy" emphasised not only the need to meet people where they are, but also the need for education for the police and public:

> The biggest thing that I noticed with them specifically is they've had some sort of trauma that they don't want to talk about. Especially with mental health patients…. I wouldn't judge them. The other thing I would do is I usually remind them hey, I know what happened to you and I know you told me that and I appreciate that. I'm just looking out for you and making sure you are okay.

“Jordan” took the same approach. She explained that the trauma experienced by vulnerable populations was not only significant, but ongoing, often due to court or societal expectations. “Jordan” stated:

> I was really immersed with a lot of vulnerable women down here. Mental health issues, women who are trying to get their kids back and don't even have housing. They just keep getting snapped back to that family unit [homeless community] that they just long for.

The experience of front-line officers and advocacy professionals was often frustrating. Participants articulated the need for increased supports, but also for increased understanding. Along with police executives, advocacy, and medical professionals, they recognised that many in the vulnerable population have little choice in where they have found themselves. “Sidney” put it this way:

> Those living with addiction need to be part of the conversation. You talk about stigma, right? Oh my gosh, I mean all druggies are criminals and you know you've heard that and it's like actually no, there's a lot that are using inside, in silence, using in their homes that are working, employed or parenting. When people feel like they are valued and they matter, then we can work with their trauma and we can work with their addictions.

Police executives recognised the need for increased understanding and have seen positive changes in the past several decades. Although it was slow to materialize, collaborative approaches allowed for increased information sharing and outreach to vulnerable populations. Still, participants advocated for increased contact with street entrenched persons to build a rapport and relationship. In their view, building rapport was more effective than straight enforcement, especially when trying to introduce people to supports. Rapport was also essential in reducing negative and even violent interactions between police and vulnerable populations. “Kennedy” recounted one such incident:

> We were at a file with the ACT team to give an injection to a guy and I was in plainclothes…. a guy grabbed the back end of my gun and I was just trying to wiggle my way out of it. The other homeless guys started beating on this guy because he was touching me. Like he wasn't allowed. I'm one of theirs. That was a huge moment for me. I realised, okay now I'm part of the pack and I was accepted. It was that respect that started removing the barrier.

Similarly, "Jordan" realised that police could be actively supporting vulnerable populations with compassion while still maintaining their role as a police officer. In this particular case, she was working with an advocacy group and simply talking to the clients and building rapport. She recounted one particular incident that spread throughout the groups as a sign that she could be trusted:

> Girls come in and they ask who are you? I'll tell them I'm police, and that's what you just want. You're just there…So it was like just go down to where the masses are and see if there's anybody we missed or anybody that wants to commit. A girl came through the front doors and just kind of slammed the doors and she said there's this effin guy out here, parked outside here who won't leave me alone. I thought well I can do something about that. So, I go downstairs, and the car is there, and the guy is there and sure enough the guy was wanted…. and then there's a tow truck, and then this guy is gone in the police wagon. So, I came back in and the girl was there, and she looked at me and she says who the F are you and I said, well, this is who I am. So, from there I think it was more of a word-of-mouth thing that happened, and I started to get more people kind of chit chat and then chit chatting and then it just kind of worked.

Police executives agreed that developing and maintaining a connection to vulnerable communities was a critical component of effecting change. To that end, they felt that community involvement and planning were important parts of effective collaboration. They viewed outreach and connection as effective means to connect with vulnerable populations from a policing standpoint, but also with a view to connecting them to services and support. They emphasised the importance of community acceptance. Regardless of the approach, the community needed to be a part of programming efforts. Without support from the community, it was likely that stigmatisation would continue. As "Alex" stated:

> But we can't forget our community in this conversation. I think our community is turning and they're getting, frankly, pissed off because of the degradation of the neighborhoods. I think what we're trying to do is stop stigmatisation, but it's actually getting worse in a way because people are so frustrated with the crime, like with the shopliftings and those survival type crimes.

Inasmuch as efforts to prevent stigmatisation were important, participants felt that outreach programs needed to be expanded. Part of the reason for stigmatisation was the lack of understanding of the root causes. Outreach was seen to bridge that gap to the vulnerable population and the communities they were in. “Charlie” described it as follows:

> The ongoing stigma of mental health persists in spite of education and so forth. They are disenfranchised from any form of power and hence they do not have a voice. Individuals and businesses with money behind them, and lobbying groups and so forth have a voice. Typically, people with mental health issues, and people with addictive issues do not have a significant voice compared to those that could make a difference, especially policy makers. There has to be a commitment to it as a high priority. I mean, we are only as strong as our weakest among us, and so if we are ignoring the weak or just paying lip service to it, then we are really doing a disservice to the rest of society.

Most participants agreed that it was important to meet vulnerable populations where they were in their lives. For instance, the notion that treatment can only be achieved through abstinence was rejected in favour of a broad spectrum of supports from abstinence to iOAT with integration into assisted living and fully supportive housing. Participants agreed that there was no one size fits all approach to these social issues; however, they recognised that many communities still believed that the road to support must start with a commitment to “get clean”. Participants felt that different approaches designed to meet people where they were at would be the most effective, since everyone has come to where they were by a different path. “Blake” put it this way:

> We are willing to try these different things, and I do not think there is one size fits all solution. And the other thing I will say about that is that if you have 10 people that are addicted, all 10 people have a different story. They have 10 different treatment plans.

From a medical perspective, “Jules agrees”

> Yes, you always have to meet people where they are at. Everybody's going to be different. So, your wrap around health services has to be able to meet people where they are at. Stigma keeps people from getting what they need when they need it, wherever they're at. We have to understand, this is not a knowledge gap, this is addiction.

Participants agreed that the need for new approaches outweighed society’s moralistic views of drug addiction and social disorder. They stated that these new approaches included medicalised drug treatments that went beyond abstinence. As “Clarke” put it:

> Well, it should just be providing care, and providing evidence-based care. Get over yourselves.

According to participants, communities and support agencies had the opportunity to realise immediate changes by taking an evidence-based approach. Outreach programs were important, but they gained their success through the human element. Participants felt that if they could affect individuals where they were, they could cascade that into meaningful, broad spectrum change. “Blake” provided a personal example of the importance of meeting people where they were and accepting that there were multiple means to measure positive change. While this was a unique situation, he felt it exemplified the successes that could be achieved by removing stigma and taking action:

> We all knew [him] back when I was on the street years ago. They said, oh, you know, he really wants to meet with you [in your current position]. So, we went and saw him, and I met with him. I sat down with him for an hour and we were chatting, and you could tell he still had severe mental health issues, but he was clean. He was in a nice room. He was joking around with staff that lived there. He was on his medication. He was seeing workers and he was getting his life back on track as much as he ever will. He never will be somebody that would fully be a functioning person in society, but he had become a bit of a leader in his group. He thanked us for getting him into this program. He died unfortunately of medical issues that he had going on inside his body after 30 years on the street of neglecting his body. I still have that thing that he gave me, but he was the

> example. This is somebody that I thought was so far gone, like one of the most bizarre people you'd ever deal with. It was humane and he was functioning really well.

Medical and advocacy participants agreed that evidence-based approaches and investment were key approaches to reducing stigma. Both groups felt that despite the evidence of success, such as the example offered by “Blake”, it was unfortunate that bylaws and elements of the criminal justice system were still being used to target vulnerable populations, even though that approach was ineffective. “Jules” stated:

> You know, we also have this dichotomy between our charter rights, which say that we cannot impose treatment on other people... People have a right to not take their pills until they hurt somebody, right? It is a dichotomy, right? We live in a free country that cannot impose treatment on other people. That is the crisis of living a democracy. And then there is the other side of the democracy that says we should just lock people up.

“Robin” agreed with “Jules” that all too often stigma drove decision making and policy by using criminal justice approaches that would appear to be more economical, but actually cost more in the long run than effective housing and support:

> And you can even see the science behind it, right? You can actually see the studies that show that it is cheaper. It is cheaper to give someone money and house them than it is to manage everything that goes on with homelessness, right? It is economically smarter and a smarter move socially, except maybe in this one context, if your morality includes retributive justice.

Participants felt that moral standards, as opposed to evidence, caused some of the decision-making processes to default toward the criminal justice system. According to “Skylar” and other advocates, the stigma associated to this was the result of the view that vulnerable populations were considered “lesser than” tax paying citizens:

> There is a stigma. There is still feeling that many of the people we serve are disposable, and they're not. Its changing from society’s view but it's also more so “what is our responsibility to do so”?

Police participants agreed. They stated that they saw the suffering of vulnerable populations firsthand and were frustrated by the systemic intolerance towards them. Police participants at all levels stated that they were looking toward government to set policies aimed at support rather than enforcement. “Avery” summed up the feelings of the police and other participants:

> If I didn't have the solid family structure that I did growing up, I could very likely have been out there in the same boat. It is about swallowing your own ego and realising anyone can be one of these people. That makes you humble. Eventually I started to realise we are going about this so wrong, like so wrong. I would be lying to you if I if I told you that I didn't have some guilt about, you know, how we did this in my early career.

Theme Six: Decriminalisation of Illicit Drugs

Although all six themes in this study are intrinsically linked, the desire to investigate and implement improved treatment and care plans was the thread that most often linked all six themes. In particular, participants felt that decriminalisation of illicit drugs, leading to effective treatment systems, such as iOAT, was the way forward. Regardless of their background, all participants believed the current criminal justice approach towards vulnerable populations was not only ineffective, but morally wrong.

Decriminalisation was supported, especially by police executives, all of whom supported the Canadian Association of Chiefs of Police (2020) report recommending the same. However, they did include a major caveat stating that decriminalisation should not be just about refusing to charge someone for possession, but it should be a key building block for a full spectrum of supports and infrastructure. Medical participants agreed that simply refusing to charge vulnerable people may feel good in the short term, but it did nothing to address the root causes of their suffering and would do little to change societal impacts without intensive support.

“Blake” stated that police would always have a role in criminally prosecuting certain individuals, but the approach taken by police in BC was changing to pathways of care:

> Possession for the purposes of trafficking, we will still do that, but we are not focusing on possession. We just find it honestly a complete waste of time. There will be exceptions where somebody has been repeatedly asked not to use in a school ground, or in a park, or in front of kids, then there may be cases where we will take an alternative approach. There could be cases where you're dealing with somebody that's a chronic offender. Somebody on parole, something like that. So, we would take a different view, but generally speaking, people get a bit of a pass on drug possession here and they have for many years because we have not seen any good benefits from the criminal justice system coming out of charging people with possession. We think that there are better paths that are more suited for those people to help them, right?

“Taylor” and “Alex” agreed that police have resisted charging people for simple possession for a long time, citing the futility of the process. “Taylor” stated:

> Not to speak for crown counsel, but they are not prosecuting simple possession offenses for a variety of reasons, not the least of which it does not seem to be effective in deterring that behaviour. It clogs up our court system substantially. I think this is welcome from our perspective. We certainly could not deal with the volume of dealing with individuals for simple possession.

“Alex” agreed with the ineffectiveness of charging people who were suffering from a medical issue:

> We will not arrest unless there are extenuating circumstances, but that has actually been put in a policy by the [Public Prosecution Service of Canada] now. With their new policy, and it has always been made clear that we want to find different approaches…. I think I have seen a couple of times where we disrupted prices slightly but that was very short term. We as police leaders have to stop being naive that were ever stopping the supply. We need to come at this from a different angle and that is what I think the safe supply angle is.

Advocacy participants agreed that new approaches were required but cautioned against maintaining an “or else” mentality with respect to using the criminal justice system, except when required for serious matters. They called for a more well-rounded approach that did not

use enforcement to force cooperation with treatment but stopped short of suggesting full legalisation. “Robin” put it very clearly:

> I would not be willing to take anything off the table at this point, but I can tell you that for the most part, legalisation so closely resembles criminalisation that it can often produce the same results…but there needs to remain a criminalised element, that if you do not follow the legal route, you will be criminalised. You are not going to get rid of that criminal aspect to things, so in that regard they almost have come together. With decriminalisation, as well as medicalisation, you have to almost treat it more like business where there are other forms of regulation and not just criminal forms of regulation… we need to find alternatives because I think that it is so easy to use the blunt force of criminal law to try to address social issues, but all it does is exacerbate.

“Reilly” emphasised the importance of multiple access points to a treatment system, and thought it would be self-defeating and contrary to the goals of decriminalisation if police were the primary access, which would have the effect of continuing traumatisation in vulnerable populations:

> They [Canadian Association of Chiefs of Police] endorsed decriminalisation, but I did not hear anything about how we can free up these public resources so that they can actually go to drug user groups who can in turn serve their peers. It actually means will have more policing, because now they will be doing the referrals, which is frankly, ridiculous. If you talk to anyone who uses drugs, the last person they want to talk to is a police officer.

Participants felt that current Canadian drug policy was focused on the wrong target by an over response to perceived criminality, as opposed to targeting higher level traffickers and violent predators. Again, they felt that treatment and support, with a view to addressing root causes, should be the approach to vulnerable populations, rather than enforcement. “Jules” spoke of the need for more collaboration and resources, citing governmental response to the COVID-19 pandemic as an example of how well this could work if there was political will:

> We are losing more people to overdoses than we are to COVID. We're having the grimmest months on record. The level of coordination interprovincially with COVID has been exceptional, but the level of coordination with addictions has not. That is why our

> children are continuing to die, because it's unpopular to save marginalised, addicted people. These are stigmatised people. I think of the Dionne Warwick song *Walk on By*. It's a disposable population. I've seen these people lose their children. These are these are young people that are getting killed by fentanyl.

Police executives agreed with "Jules'" frustration and felt that they bore the brunt of ineffective policies that criminalised vulnerable people, despite their experience that the current system was broken. "Drew" stated:

> It is naïve to expect that hammering the heck out of the users, so somehow there is now no market to sell to, will cause the suppliers and the traffickers to go away because nobody wants to use it. We have already charged the heck out of all the users and it does not work. That is not practical. So again, there is balance, but it should be weighted, obviously on the dealers and the suppliers, right?

"Blake" agreed and advocated for treatment and pathways of care for addicted people, while targeting those that took advantage of them:

> So, from a business side it makes sense for these drug dealers to use it and then the other side of it is that they are killing people because as you know they mix it up and it's not evenly distributed, and you get hotspots and people are dying.

On the front-line, "Kennedy" has seen the influx of Fentanyl and tainted drugs firsthand. She stated that the current system did little to address why people were addicted and became homeless. She was supportive of decriminalisation. She provided the same caveat as police leaders in saying that infrastructure and support had to be in place first, as well as the acknowledgement that these types of drugs were so dangerous that legalisation might be a step too far:

> It is a little harder to watch some of this. One of our big buyers right now is a [school] teacher. I just cannot wrap my mind around it. I cannot even disclose this to the school until I get charge approval that [they are] buying fentanyl and touching kids… I definitely do not think we are dealing with it the proper way.

"Avery" also saw the ineffectiveness of using the criminal justice system to address obvious medical issues. He experienced the slow turn of the system and its detrimental effect on wellness:

> It is another roadblock to their recovery as well because what ends up happening is now, they build up all these convictions. Next thing you know they cannot get a job…so it is a real barrier to recovery when we do that, when we really chicken shit these guys with all those types of things. I do not think it is that the appropriate way to go.

Even using drug courts as an alternative to traditional sentencing was questioned by front-line officers. While they agreed with their executives that a multi-faceted approach was required, they saw firsthand the trauma experienced by vulnerable populations and understood how difficult it was to move away from their addictions without adequate supports. "Jordan" was supportive of decriminalisation but offered the following caution:

> They often accept drug court over immediate jail, but they just cannot do it, it is just too hard. It is just too much. Maybe there are baby steps into getting through drug court. Maybe just do not go slam and right into your sentencing. I mean, it is great the supports and the programming that they have in there, but I do not even think I know one person who has actually made it right through drug court without, you know, getting yanked back or something.

Alternatives to the current enforcement and sentencing approaches were supported by all participants; however, advocacy participants were concerned that entry into proposed support systems was still very police centric. Just as "Jordan" indicated, "Reilly" and "Sidney" were concerned that using the police as a primary access point still traumatised and marginalised vulnerable populations by viewing their behaviour as deviant to the point of police involvement. Similar to "Blake's" view that there needed to be more discussion about upstream drivers and prevention, "Reilly" cautioned against a decriminalisation approach that relied on extensive police involvement as opposed to medical and advocacy support:

> When I hear alternatives to sentencing, I am still thinking that is like diversion at the court level, and it sounds like people are still interacting with police. At that level of interaction, an officer is choosing to use their discretion…If these are not criminal issues, why are they being subject to police interaction? You know it is kind of like this carrot and stick where you are told if you are going to go this [drug court] route you are going to plead guilty. That is how you get to this. That is how you get access to all this support, which is already like really problematic, because you might still want some of those things. You just need to plead guilty. Not a big deal, oh, but if you mess up, you are going back to jail and you are serving your whole sentence.

"Sidney" was also concerned by the carrot and stick approach to gaining support that seemed to be offered as an alternative to jail:

> Harm reduction and treatment are needed but we know it is not there. But what we do though, is we have this criterion that to get in you have to be clean and sober. You and I both know that when you have arrested someone, they may want to go to treatment right now. Put me in treatment right now, but in an hour, they are going to be FU, I am not going to treatment, right? So, when we have their undivided attention and their will to do it, we need to actually be able to get them there.

Participants advocated for more research into effective approaches in other countries. The "Portugal" model, as discussed above, was repeatedly cited as an example of effective policy. "Robin" felt that without such innovative approaches, the Canadian system would continue to repeat its focus on criminalisation:

> I think that you do see some interesting things happening in other countries who are starting to think maybe we should think about alternatives. I wish we would think about alternatives because I think that generally speaking again, we are setting up a system for failure. We are setting up individual officers for brutally unsafe situations and I think we are contributing to issues of corruption. I hope that we are coming into an area where we are starting to think things through a little more carefully. I do not believe there is enough political will to make those changes yet.

"Jules" agreed with "Robin" about the lack of political will. He cited progress in other countries and was concerned by the lack of political or societal will to follow proven practices:

> It is going back many, many years, but I am very well versed on European practices. We have a long way to go. So, for example in in the early 90s when we went to Europe you could not find a bus or train station of any kind without sharps and needle exchanges.

> They just were very liberal. So, I think from a Canadian, North American perspective, Canada is leading the way …. but when you compare it to more of the progressive European countries, we have got a long way to go.

Participants agreed that the need for a decriminalised approach to addiction and substance abuse was the way forward in building wellbeing in vulnerable populations. Advocacy participants viewed this not only as a policy decision but a basic human right. Their assertions were backed up by evidence offered by the medical participants in this study, as well as by police participants who have seen positive changes in otherwise difficult clients. “Skylar” studied programmes in other countries:

> What is that one quote? Something about the test of society is how it treats its most vulnerable? That is true, you know, and you see models in Europe that literally take [addicted] people who are like that. It's not so much forced, but there is concern for their own rights. I think a lot of people will never know what it would be like to suddenly lose everything, fall into addition, fall into depression, which is a very underrated mental health issue. It can cripple you and suddenly everything changes.

Medical participants have seen effective treatment programs in Canada and are frustrated by what they perceive as a lack of political will to move forward with wider use of these programs. “Clarke” explained that there was still a great deal of criminality and stigma around illicit drug use that was driven, in part, by a continuing “War on Drugs” attitude:

> I mean, the fact that our clinic is providing prescription heroin, and it's been doing so for nearly ten years is a sign of success. If we were doing this to the south of us, we could be arrested and put in jail, so Canada is further ahead than our neighbours to the south. I don't like the word harm reduction. To me, it's just care.

“Clarke” went on to cite statistics and evidence of the effectiveness of iOAT and other such programmes that provided treatment beyond abstinence and looked at ways to effectively stabilise those suffering from addictions as part of an overall strategy:

> Providing prescription heroin to this population is clinically cost effective. Looking at our data, between 70 and 80% are retained in care, including housing and treatment. We

> need to find more ways of getting care like this to folks…this is from our studies and other studies, but [this treatment] also reduces mortality and it reduces crime. Both property crime and violent crime.

While participants were hopeful that new programs could be put into place that would address root causes and trauma, they were concerned that the urgency was being under appreciated. “Skylar” has seen the urgent need for change in her city:

> But it is turned. Fentanyl has turned this community where the community members say I do not even recognise my peers. That they are literally walking dead. It is a hard thing to reconcile.

As “Charlie” put it:

> I think the treatment element of it needs to be emphasised, especially for those that cannot take part in treatment for various reasons because of mental health issues or just because of how disenfranchised they are from society and their ability to function in society…. we do need to look at more treatment rather than criminalising or charging people and pushing them through a system that will probably enhance the issue, the problems.

Participants were asked for their views on the four pillars approach of enforcement, prevention, treatment, and harm reduction. While their views on this program varied slightly, they all agreed that it was good in principle, but not in implementation. At issue was the inability to effectively implement each component in an effective manner. Participants felt that enforcement and harm reduction seemed to be the mainstays of the program with unequal and limited representation and collaboration between sectors. As “Blake” put it:

> I am big fan of the four pillars, but you know, it has been like a dog running around on two legs for many years because there has been a huge gap.

“Alex” agreed:

> But the four pillars is a bomb. Valuable approach, but I think sometimes we put too much emphasis in one or two pillars, and we have not maybe done enough in the other pillars.

Advocacy participants were also supportive of the concept but were disappointed by the results to date. Their viewpoints linked back to the need for more resources and an understanding of the trauma faced in vulnerable populations. In “Robin’s” experience:

> I don't think it was ever fully implemented so it is hard to evaluate it because it has never actually happened. I think there is a lot of good ideas behind having a more holistic approach to all of this, but I think that again it is the reality of politics, the reality of allocation and support, the relative training, the reality of who has the capacity to do any of this stuff. We never properly implemented anything relating to it, we just kind of said we would, and put a couple of things together, which is never the intention behind that approach.

Police participants agreed. “Drew” stated his concern with the four-pillar approach was a lack of balance and resources:

> Everything is about balancing right? It is the same thing with abstinence or harm reduction. Not even thinking about trying to help them long term, but just give them all the needles and all the drugs in the world. Yeah, they are not going to get hep C, and they are not going to get disease potentially through a needle, but they are going to completely wreck their bodies, and they are going to die anyway, right? So, balance that off with harm reduction until we can get them into treatment, maybe some abstinence. If not abstinence, then I mean stabilising them and giving them some other comfort might get them along that path.

When asked for their views on developing effective policies around the treatment and support of vulnerable populations, police participants were quick to suggest the need for prevention. As “Blake” put it, there was a need to address upstream drivers before communities had to deal with downstream behaviours. All participants agreed with the need to address preventative measures and support, especially before behaviours manifested themselves in perceptions of violent or deviant behaviour. As a front-line officer, “Avery”, and “Blake” as an executive addressed the need to prevent vulnerable people from entering the criminal justice system. “Avery” stated:

> When you are dealing with somebody who is addicted, who is dealing with the disease, you cannot expect to drop him off at [treatment] and in six months they show up and they are all healthy and looking good, right? The disease itself is continuous, it will progress.

"Blake" agreed with the current inability to continually support people, even if they were in the system:

> If you walked into hospital and he had a heart attack or broken leg, they would know how to fix it, but if you show up addicted to drugs, they will say okay, see you later and send you back out the door. We will have a spot open in a couple of weeks. But in two weeks you know your window is gone right? I cannot send them back out for two more weeks. We need to do it now.

Similar to "Avery's" concern, "Jordan" emphasised the need for continuing care, including the assurance that people coming out of treatment would be set up for success:

> When you finish detox and say you go through the recovery, then what? you come back to your same SRO [accommodation] down here. Except now you're the sober one for however long before your neighbours down the hall decide it's party time again and you are triggered…

Despite evidence to support increased access to treatment and stabilisation, participants were concerned that current approaches were too lethargic to make a broad impact on the wellbeing of vulnerable populations. All participants felt that decriminalisation of illicit drugs, including the implementation of a safe drug supply, would lead to a reduction in the criminal distribution of harmful drugs, such as Fentanyl, and other toxic drugs. They agreed that a significant investment in infrastructure would be required to ensure the system worked, including housing, treatment facilities, and a broad spectrum of community supports. Medical participants felt that treatment options did not need to be confined to a clinical setting, but could be implemented into supportive housing systems, especially with medical professionals embedded in the facilities. In particular, police emphasised the need for proper infrastructure

prior to implementing decriminalisation policies fearing that simply ignoring possession would keep vulnerable populations under the control of predatory drug dealers without addressing the root causes of their vulnerability. “Alex” warned against this issue by citing examples currently underway in BC:

> And we are the most lenient province in Canada with drug use, and it is because we have not built the infrastructure. There are politicians who naively think we just announce that we are going to decrim drugs in our city because that is the right thing to do, and everything will be better.

Other police executives agreed. “Blake” stated:

> We need to take people that are addicted to drugs and we need to move them into a healthcare pathway, as opposed to criminal justice system pathway which does nothing. But we also need to be able to provide health supports for them in the first place. It is not as simple as people say. People say just decrim everything and everything will be fine. I say to the mayor and other people they know it is not that simple. I will argue we have de facto decriminalisation in [this city] for 10 years, but people are still dying from a poison drug supply. People are still getting it from illicit sources and organised crime. They are still breaking into cars and breaking into your house so that they can afford to buy their drugs. So just decrimming it tomorrow, does nothing. You actually have to have a plan, like a pathway to get them into health.

“Alex” stated he was very familiar with the Portugal model. He stated that while it is a good program to create a basis for Canadian response, it was important to build decriminalisation programs that were specific to the Canadian context. For instance, he cautioned that Portugal has one health system, while, in BC, there are five separate health authorities:

> So, my argument was to build a system, like a Portugal, who said do not copy us, but learn from us. We need to build a made in Canada approach that will help people…but I am just frustrated that the rhetoric has sort of taken a life of its own, and everyone is so quick to just say just decriminalise, without the infrastructure in place first.

The main concern presented by all participants with simply saying that the police would decriminalise without establishing the necessary infrastructure was the issue of supply.

Although all participants urged the necessity of a safe drug supply, they did not have enough research to advise how it would operate, especially if the illicit supply was not curbed first or left to wither away due to lack of demand. “Alex” continued with his experience:

> It makes no sense. So, we say okay, we have a place where you can actually go once you buy your poison on the street, which we know is highly toxic, highly dangerous, and there is a good chance it is going to kill you if bring it into this place [supervised consumption site]. We are going to let it kill you, then we are going to revive you, kick you out again, go buy more drugs and repeat.

From a medical perspective, “Clarke” agreed with “Alex”. In his view, and in the view of advocacy participants, pushing forward with harm reduction initiatives and decriminalisation, while allowing the illicit, toxic drug supply to continue would set up people for failure, even if there were effective treatments:

> Because knowing what we know now about medicalising or providing pharmaceutical options, I do not think we should have supervised injection sites without offering a pharmaceutical alternative to the street supply. Standalone supervised injection sites are no longer adequate. When they go hand in hand. When we provide decriminalised or legal heroin, but it is in a medicalised context. If it was just decriminalised and people still had to rely on the illicit market or the street market, you would not see the benefit. There needs to be a medicalised or legal access as well.

Participants agreed that a vital component of any move towards decriminalisation was the need for treatment. Harkening back to earlier comments on meeting people where they were, participants urged for treatment on demand in multiple formats, including decentralisation, housing supports, and medical clinics. Although all participants were supportive of this concept, and the commensurate programs of developing safe drug supplies as a form of stabilisation and treatment, they were frustrated with the slow pace of implementation. “Jordan” stated that the lack of availability was the biggest issue with supporting those who needed immediate detox or support:

> For sure, it's like on demand, right? I've heard it for years; I know we need to have it, but we don't have it. It's luck of the draw, you can phone, and they'll give you a date like maybe 9 days.

As stated earlier by "Sidney," the expectations put on vulnerable people as a condition of them receiving treatment were unreasonable. "Reilly" agreed that these expectations did not set people up for success:

> That is like the type of really conditional support that relies on a deeply disenfranchised community that has very limited ability to assert their rights. On one hand, we want to divert people from the prison system, but we are going to send them through drug court before they are going to go to treatment centres or recovery houses. If they relapse, admit to, or are found to have been using illicit substances they are going to jail. It is totally at odds with the bio-medical understanding of substance use.

"Skylar" saw the dysfunction in the system firsthand. Similar to the concerns expressed by "Reilly", "Sidney", and "Jordan", her view was that setting expectations for people to be sober before going into treatment to become sober set the bar too high:

> But there are waiting lists and when we talk about low barrier, and high barrier programs you have to be clean. You are on the street, all your friends are using drugs, and you almost committed suicide the night before because you just cannot take it anymore. Then you got to jones out there and you have to withdraw? You got to detox but it is full …that window of opportunity somebody has is gone when they are turned down. I mean, you have lost it for a long time, for many, forever, right?

The manner in which a decriminalisation policy might be implemented was a concern for all participants. "Reilly" explained that the lack of political will and societal acceptance would take significant education to change:

> Canadian drug policy is stuck. It is overly conservative and cautious. It assumes that medicalisation will keep people safe and alive but lacks a sufficient critique of the medical model. I think that Canadian drug policy needs to really be handed over to peers and people who use substances to actually direct it without being fettered by prohibition, but also with the gatekeeping of clinicians.

This view spoke to the need for accountability and understanding of what works. An evidence-based approach, using information from those with lived experience, coupled with medical success was deemed the most appropriate path forward. Unfortunately, participants felt that much of Canadian drug treatment policy was centred on a very narrow view of what constituted effective treatment. Similar to "Reilly's" view, "Alex" agreed from a policing perspective that there needed to be more support for the medical viewpoints of what works:

> I certainly want doctors or clinicians to be part of this discussion. A drug dealer tries to make a user use more drugs, but in a health approach, you try to make people stabilise their drug use and eventually, hopefully, moderate their drug use.

Medical participants agreed that treatment and stabilisation efforts needed to move away from the singular focus on drug use to a full spectrum approach that recognised the very complex nature of addictions and mental health. Once again, this led back to the need for significant investment to ensure infrastructure was in place prior to a decriminalised approach. Police executives, while supportive, were adamant. "Alex" stated:

> What we are doing right now is we are putting the cart before the horse. We have not built the infrastructure. We have not built the system or the program, so we are not helping individuals …my argument was build a system first, like a Portugal model.

"Drew" went further to discuss the negative views of decriminalisation on the part of certain sectors in society that could only be shifted with education and the knowledge that effective supports were in place:

> Supporting harm reduction is important, but it has to be done right. It has to have proper resources attached to it.

"Blake" agreed that effective implementation of decriminalisation needed a concurrent push for understanding:

> A lot of this, I will tell you, is in the eye of the beholder, right? In Eastern Canada, there

> is still a more of a law enforcement, old school kind of attitude about enforcement. You broke the law and its sort of an American attitude as well. If that person is possessing drugs, then we need to arrest, we need to send them to the courts, and into jail, and that is going to fix the problem.

Finally, police executives stated that pathways to care would not work for all vulnerable people and that, at times, a criminal justice process would be needed. This was supported by other participants who stated that there could not be a one size fits all approach to effective policy implementation. Participants were keen to express the need for multiple approaches carried out by agencies working in collaboration with one another.

Chapter 5: Discussion and Analysis

This study examined current responses to addictions, homelessness, and mental health through a literature review of current approaches, an analysis of police reported crime data provided by the BC RCMP, and 14 interviews with professionals in the fields of law enforcement, advocacy, and medical services.

Statistical Analysis

While serious crimes, such as aggravated assault, robbery, sexual assault, and serious or serial property crimes consume a great deal of police effort, what became clear in the research was that police spend an inordinate amount of time responding to occurrences that are not criminal in nature. The literature review and analysis of police data demonstrated that over 60% of police occurrences are non-chargeable (Canadian Association of Chiefs of Police, 2015; Department of Justice Canada, 2018; Huey et al., 2016). The majority of these occurrences resulted from day-to-day operations of policing involving assistance to the public and other agencies; however, this number is stark in that it shows that a significant portion of police work did not deal with their primary mandate of interdicting criminal behavior. When they are dealing with incidents of a criminal nature, the statistics demonstrated that a substantial portion of police activity is consumed during the response and investigation of property crimes, the majority of which are for less serious property crimes, such as theft from motor vehicle, that typically involved low value thefts, according to police participants. Following theft from motor vehicle were mischief under $5000, theft under $5000, mischief-loss of enjoyment of property, and shoplifting under $5000; all of which are on the lower end of severity when compared to violent crime or societal perceptions of the harms of social disorder. According to

police participants, theft from motor vehicle and shoplifting were often associated to vulnerable populations, many of whom were engaged in survival-based crimes to support their addictions or their poverty conditions. This determination was confirmed in discussions with police executives, advocacy, and medical professionals who understood the root causes behind survival-based crimes. To summarise, most of the police calls for service do not involve calls of a criminal nature and when they do, they are often driven by low-level property related offences, many of which are associated with vulnerable populations who are experiencing addictions, homelessness, or mental health issues. In turn, this drives a demand for response to these issues from the public that relies too much on police response and not enough on a CSWB approach borne out of collaboration and investment. Police have become the de facto response agency to matters concerning vulnerable populations because of the lack of effective policies and infrastructure to support them through a continuity of services.

Development of Themes

The interviews specifically pointed to the need for increased investment and collaboration across sectors. All participants agreed that matters of addiction, mental health, and homelessness were often outside of their particular agency mandate, even though they responded to these issues on a regular basis. This was especially true for police participants. For instance, addiction is not a police mandate, but should fall to the medical system since it is considered a health issue. Despite this, police are often left to deal with the consequences of addiction, specifically when it comes to vulnerable people. The data was consistent with past literature in indicating that dealing with vulnerable populations required multiple agencies working together in a more collaborative fashion.

All participants agreed that policy alternatives concerning decriminalisation of illicit drugs, reduction of stigmatisation, and the development of alternatives to criminal justice responses were necessary steps to assist people suffering from mental health, addictions, and homelessness. There was also unanimous agreement that Canadian drug policy should continue with harm reduction initiatives leading to decriminalisation of certain illicit drugs, particularly at the street level. However, the discussions that arose out of this question included the need for a safe drug supply and treatment on demand. Still, all participants agreed that treatment should take precedence over enforcement when dealing with vulnerable populations, with the caveat that people needed to be met where they were at in their particular circumstance.

Participants cautioned that there was no one size fits all solution to complex social concerns. They stated that a full spectrum of supports ranging from housing to social assistance was required. In the case of drug addictions, multiple treatment options, such as iAOT, were deemed necessary, especially when concurrent disorders were present. Participants agreed that police responses, such as enforcement, were still required to deal with people who were benefiting from the misery of vulnerable populations, as well as people whose behaviours presented no alternative other than initial police response. Shifting to more collaborative models where police provide a supporting, rather than primary, role, would enable police to focus their resources on more appropriate enforcement targets, such as traffickers of illicit drugs, such as fentanyl.

Throughout the interviews six themes became apparent. There was agreement throughout the interviews on the need for collaboration across sectors. This led to a second theme that discussed the barriers to achieve collaboration and the role of police within

cooperative efforts. This led to a discussion about funding and resources as a key component of moving forward with assistance to vulnerable populations. Closely related to the reasons behind the existence of barriers to collaboration was the theme of stigmatisation. Several participants felt that barriers, especially due to stigma were caused by a societal view that vulnerable populations were "less than" the general population. In part, this was because they were viewed as authors of their own demise. As a result, these populations suffered further due to limited access to supports. The final theme focussed on alternatives, such as treatment on demand and decriminalisation. Since the focus of these interviews was to determine the policing role in bringing support to communities in general, and vulnerable populations in particular, much of the discussion centred on what police could do to increase CSWB while working in collaboration with various partners.

Purveyors of Crime Reduction or Social Engineers?

Participants felt that many efforts geared towards solving social issues were directed at law enforcement and criminal justice responses, rather than addressing root causes in the first place. Participants often expressed frustration at the lethargic pace of change when considering alternatives to a criminal justice approach, especially considering there were high levels of agreement across sectors of that need. Evidence showed the majority of crime was committed by a very small percentage of society and, in particular, by prolific offenders (Cohen et al., 2014; Plecas et al., 2014). According to the research, the majority of that crime was on the lower end of the spectrum, including low level property crime driven by survival activities due to addiction and mental health (Department of Justice, 2018). Advocacy participants agreed with police

executives that it made no sense that armed police officers were at the frontline of dealing with vulnerable populations.

Participants discussed alternatives, such as using a medicalised approach to mental health, whereby, in certain circumstances, police would not be required. While police executives agreed with this approach, they cautioned that, in many cases, police response was predicated by the service agencies themselves. Although the literature revealed that criminality was not necessarily associated to vulnerable populations, except perhaps in terms of over-victimisation, the perception that these populations were crime drivers often supported the politicalized notion that police should be involved from the outset. However, the research, supported by participant views, suggested that medical approaches that addressed root causes, such as ACEs, generational trauma, poverty, and mental health, would have a more positive long-term effect.

Just Walk on By

Stigma and a view of vulnerable populations as being “less than” others were cited by participants as a leading cause of lack of supports. Participants across the spectrum agreed that stigmatisation, as well as silent approaches at the government level, prevented effective collaboration and, therefore, effective support to these populations. Despite this attitude, medical participants cited examples where collective will towards a common goal and purpose achieved significant results. The most notable example of this was a discussion about COVID-19, as compared to the approach taken towards addictions, mental health, and homelessness in general. Participants felt that the approach towards mental health and addictions does not appear to lack funding inasmuch as it is a lack of coordination of effort. They cited the response

to COVID-19 as effective collaboration throughout medical, social, and law enforcement systems in Canada. Conversely, approaches to addictions and mental health showed stigmatisation either by considering the people suffering from them as a lower-level priority than the rest of population or by the view that pathways of care were not politically expedient.

Investment Requires Political Will and an End to Stigma

The recent exchange between the BC Minister of Housing and the Mayor of Penticton articulated the view that vulnerable populations can be seen as "less than" quite well (Fries, 2021). At one level, the provincial government was attempting to provide housing for homeless people, albeit in an approach somewhat siloed from full wrap around supports, including medical systems and mental health treatment. On the other hand, the city of Penticton was concerned with the perception of an over-burden of homelessness and the commensurate social disorder. The political battle of wills exemplified the lack of understanding of the root causes of how these people came to be homeless and does little to create long-term solutions. The mayor's statement, shown below, demonstrated the lack of political will to address root causes by classifying the behaviour of vulnerable populations as "not normal":

> "Maybe they could get rid of their addictions and mental health issues and make them somewhat normal."

It is unlikely that society's definition of normal can ever be achieved by people who do not have access to treatment and care or the dignity of the acceptance of their trauma. Regardless, the *Charter of Rights and Freedoms* enshrines the right of individuals to live free of discrimination, which cannot be curtailed simply because people do not appear normal to those in power.

Participants in the study agreed that tackling stigma was a key component of moving forward with alternatives. They also agreed that to increase collaboration, stigmatisation, and

barriers presented by a lack of political will need to be removed in favour of medically effective approaches to deal with these social concerns. However, tough on crime approaches to deal with social disorder are often more politically expedient with the general population, even though social concerns, such as addictions and mental health, should be addressed through medical support and intervention.

The 3 AM Question

Most participants considered the problem of who responded to social concerns when all of the agencies have gone home. The general population has grown overly comfortable with calling 9-1-1 to address unsightly issues or what may be viewed as socially deviant behaviours. With mental health, for example, police are often the first responders. Sending armed police officers to what should be considered medical or social issues makes little sense, but currently, there are few alternatives. It was acknowledged by all participants that to create an approach where police were not the sole responders, significant investment and infrastructure would be required.

The 3:00 AM question then becomes one of who will do the work outside of normal business hours? The effectiveness of co-responder models, such as those where police and mental health professionals are partnered in one car, was discussed at length by all participants. These types of partnerships were viewed as a good example of collaboration, although police cautioned that they are reactive in nature and often failed to address the upstream drivers of what caused the occurrence in the first instance. All participants agreed that addressing root causes and preventing socially deviant behaviours was the correct approach, which, once again, led to the need for significant investment. As an example of

expanded support, the use of assertive community treatment and assertive outreach teams was discussed. These types of proactive approaches allow police, medical, and social services to work in partnership to address root causes in advance of crisis. The literature and participant interviews made it very clear that more work was required in expanding these types of assertive outreach programs, not just in major centres, but in rural areas of the province as well (Walmsley & Kading, 2019).

Collaboration Requires Investment

During most interviews, there was limited discussion on the defund the police movement. Participants agreed that taking money from one agency to support another agency was the wrong approach in the short-term. They called for substantial and substantive investment into each of the agencies responsible for supporting vulnerable populations and communities in general. A significant portion of this discussion centred around the availability and the likelihood that other agencies would be able to respond in a similar fashion to emergency services, which was considered cost prohibitive.

As discussed above, Situation Tables are an example of effective collaboration that allow police, social service, medical, housing, and community support agencies to work in collaboration to address issues concerning acutely elevated risk in the community. By working together to support people at risk, participants in Situation Tables can prevent crisis and connect vulnerable populations to the supports they require. While Situation Tables are a good example of collaboration at the frontline level, it begs the question why such cooperation does not occur at higher levels? For instance, the current review of the *British Columbia Police Act*

presents an opportunity to codify responsibilities and opportunities for that type of collaboration.

Participants agreed that barriers, such as privacy and individual agency mandates, should not trump wellbeing and the safety of individuals. They cited privacy concerns as one of the main barriers to effective collaboration, even though the legal aspects of information sharing in the name of saving lives and creating wellbeing have already been resolved. Again, the Situation Table model is an example of effective information sharing across agencies and maintaining an individual's dignity. Participants argued that if privacy sharing and collaboration worked at the front-line level, increased support, infrastructure, and resourcing should be legislated to enable this support throughout all levels of government.

Decriminalisation

Participants in this study cited multiple examples of effective collaboration leading to pathways to care for vulnerable populations that removed stigma and criminal justice approaches in favour of support. The need for housing was a recurring element, but so too was the need to have supports available to meet people where they were. Participants felt that decriminalisation and treatment should be primary responses to current social concerns, while recognising police responsibility to interdict illegal drug operations, predators, and organised crime. The motivation behind moving to a decriminalisation strategy for illicit drugs was not simply about reducing police occurrences and court burden, even though those may be positive outcomes. Instead, decriminalisation policies were envisioned as building on community safety and wellbeing for all citizens, including vulnerable populations. Participants agreed that decriminalisation was an important step forward to build on existing harm reduction strategies

through expanded outreach, treatment, and stabilisation through housing. Police executives cautioned that for decriminalisation policies to work, significant infrastructure was required prior to the implementation of the policy. The Portugal initiative relied on just such an investment and full collaboration across sectors prior to implementation (Canadian Association of Chiefs of Police, 2020; European Monitoring Centre for Drugs and Drug Addiction, 2019).

The requirement to meet people where they were in their respective journeys was articulated by medical and advocacy participants with respect to decriminalisation policies built on treatment. Again, they emphasised that there was no one size fits all approach, further supporting the police view that significant investment was required prior to implementation. Simply expecting decriminalisation policies to reduce harm in communities without follow on supports would, in the view of participants, further stigmatise an already vulnerable community by forcing them to maintain relationships with illicit drug dealers and organised crime. Instead, a safe drug supply should be available in a medicalised and prescribed manner to eliminate the illegal market. Once again, this suggested the need for significant infrastructure and resourcing at the medical level to allow for medicalised interventions, such as iOAT, prescription medications, and abstinence treatment programs on demand. Once in a supportive system, multiple alternatives for dispensing medication could be made available ranging from outpatient iAOT to coded dispensing systems in supportive housing facilities.

Chapter 6: Recommendations: Building Pathways to Care

The interviews indicated multiple opportunities to build pathways to care, such as supportive housing and medicalised approaches to addictions and mental health. The views of participants were supported by the research and cannot be overstated in terms of the need for collaboration across sectors and significant infrastructure investment. This study presents the opportunity to investigate the most effective pathways to care, to move away from a criminal justice approach to one where vulnerable populations are treated with compassion and understanding with a view to resolving the conditions that led them to where they were. The following recommendations are built from participant suggestions and the review of effective strategies found in the literature review:

Recommendation 1: Cross Sectoral Cooperation

Legislation and policies should be strengthened to create collaboration across sectors. Collaboration should include front-line initiatives, such as Situation Tables, assertive treatment and outreach programs, treatment on demand, and alternatives to short-term incarceration. Changes to policies and legislation should include a clear definition of agency roles and responsibilities, both in terms of their unique mandates and how they interact with each other. Multiple access points are required to allow those needing support to connect to resources, regardless of how they come into the system. Policy discussions should centre on evidence-based initiatives, such as iAOT, to move away from punitive measures toward a health and social support approach. Police should be able to refer vulnerable individuals to a broad spectrum of support ranging from increased restorative justice approaches to entry into treatment and supportive housing. Concurrently, support agencies should be able to work in

collaboration with police for protection and to maintain accountability of individuals who are not readily accepting of support.

This level of collaboration will require significant investment in terms of physical resources, such as housing and treatment facilities, as well as substantial funding to supportive programs. Alignment between agencies and supports utilising evidenced-based approaches should be considered to reduce duplication of effort and to properly allocate existing budgets. Data and information sharing should form an integral part of the approach towards effective collaboration, while respecting confidentiality and private information.

Recommendation 2: Redefining the Role of the Police

Criminal justice policies should be representative of the community as a whole, not a specific and identifiable component thereof. In this case, efforts to use enforcement to control the social and health issues associated to addictions, mental health, and homelessness should be eschewed in favour of evidence-based interventions, such as medicalised approaches to drug use, outreach support, and access to services. Given the current workload of police, over 60% of which is consumed by non-chargeable occurrences, efforts should be made to re-allocate police resources to more serious criminal matters, including drug importation and trafficking, serious violent crimes, crime reduction through prolific offender management, and crimes of exploitation, such as human trafficking and financial integrity. Police should remain a part of collaborative efforts to support vulnerable populations by supporting other agencies to meet their needs before exposure to the criminal justice system. Each community should conduct needs assessments specific to their situation with guiding policy and legislation from the provincial and federal level. When developed, needs assessments could be implemented

through funding and support from provincial agencies to facilitate program success. Provincial and federal policies should be evidence-based and guided by approaches that are proven to be effective, such as Situation Tables, supportive housing, and medicalised support to vulnerable populations.

Recommendation 3: Reduce Stigmatisation and Increase Understanding

The removal of barriers to collaboration should begin with an understanding of root causes of addiction, mental health, and homelessness. The intent should be to reduce the negative effects of stigmatisation against vulnerable populations to allow for holistic approaches to overall community safety and wellbeing. Similar to the first recommendation, policy development should focus on providing evidence-based research to governmental decision makers to create understanding within their communities, as opposed to vilification. Dated notions that vulnerable populations are somehow the authors of their own misfortune should be removed in favour of actual understanding of why these populations exist, what can be done to reduce their suffering, and evidence-based approaches to restore their dignity.

Holistic approaches respecting the dignity of the individual should be geared to people's specific needs and the overall community in general. This should include training programs for police and community leaders that create an understanding of root causes. Wherever possible, when the behaviour of vulnerable individuals does not present a threat to public safety, alternative approaches, such as medical intervention, social outreach, and stabilisation through housing should be priority responses before defaulting to the use of police and the criminal justice system. Prevention of upstream drivers to negative behaviours should take precedence over reactive enforcement. This can be made possible through increased investment into co-

responder models, peer support and experience, ACT teams, outreach programs, and early intervention programs to prevent vulnerable population interaction with the justice system as the default approach, when it should be the last resort.

Recommendation 4: Decriminalisation of Certain Illicit Drugs

Participants felt that decriminalisation and treatment should be primary responses to current social concerns, while recognising the police's responsibility to interdict illegal drug operations and organised crime. The motivation behind moving to a decriminalisation strategy for illicit drugs was not simply about reducing police occurrences and court burden, even though those may be positive outcomes, but decriminalisation policies should focus on building CSWB for all citizens, including vulnerable populations. Police executives cautioned that for decriminalisation policies to work, significant infrastructure was required prior to the implementation of the policy. Before undertaking legislative change to implement decriminalisation, infrastructure should be funded and established to create multiple access points to treatment, extended and coordinated outreach programs that may or may not involve police participation, housing stabilisation, criminal justice diversion systems, and human resourcing to operate a broad spectrum of care. The Portugal model is often cited as an example of this broad spectrum approach since they were able to mobilise infrastructure and cross sectoral response to their program. Police participants supported this model, but pointed out that the Portuguese officials themselves recommended that a Canadian approach should learn from, not copy Portugal. They cautioned against simply importing and adopting their model due to the differences in social and governmental systems.

Chapter 7: Limitations

This study analyzed police involvement with vulnerable populations through a literature review, data analysis, and interviews with various professionals involved with these populations. These interviews yielded valuable perspective in the application of the literature and data to real life situations. Regardless, several limitations to this study should be recognised to provide context for further research into the concerns faced by vulnerable populations:

Limited Sample Size

In total, 14 individuals were interviewed during this study, all of whom had significant experience in policing, advocacy, and medical approaches to mental health, addictions, and homelessness. Despite the relatively small sample size, the experience of the participants was evident in terms of the understanding of root causes, current policies and approaches, and the overall societal concern with respect to this population. For instance, police participants consisted of senior officers with dedicated front-line experience with these concerns, as well as executives who had actively participated in the crafting of legislation and policy at the provincial and national level. Advocacy and medical participants had also published guiding documents to describe evidence-based approaches to develop effective policies to support vulnerable populations. The snowball sample methodology relied on references from initial participants to others who likely shared similar views. Nonetheless, the findings in this study were substantiated by the cross sectoral agreement of the participants. All participants were quick to articulate the need for increased collaboration, investment, and support for vulnerable populations to the point that the themes were not only apparent, but consistently similar in their viewpoints, regardless of background.

Further research can build on these experiences by expanding the participant base to another advocacy and medical professionals, as well as interviews with people with lived experience to bolster the qualitative nature of the research. Furthermore, interviewing other police agencies, beyond large centres, would shed light on concerns specific to those communities for a more complete understanding of societal issues.

Limited Geographic Context

Although participants had experience dealing with at all levels of government policy development, most were from the Lower Mainland of BC. The data set used in this study was specific to the BC RCMP with limited consideration of municipal police force data. Despite the single data set, there is confidence on the basis of the literature review and interviews that the BC RCMP data set is representative of overall policing and crime trends in BC and Canada. Similarly, while participants in this study had limited direct experience working other jurisdictions outside of BC, their professional experience and interaction with other agencies in Canada allowed for a fulsome understanding of issues in other communities throughout the country. Still, future research could be enhanced by focusing on specific communities outside of major population centers to develop a broader perspective of societal issues in rural areas, smaller towns, and different provinces. Notably, a significant portion of the literature referenced studies and experiences from outside of Canada. Future research would be useful to determine specific Canadian context with respect to the number of mental health and addictions occurrences, including outcomes of Canadian specific approaches to these issues.

Limited Perspective

Although this study relied on interviews from a broad range of participant experience, it was focused on police interactions with vulnerable populations. This study determined that police responses to dealing with societal concerns are over-represented when compared to other agencies. While this is reflective of police concerns, there is scope for further research with respect to the concerns of other agencies in the health and social support sectors. The broad spectrum of participant experience coupled with the literature review lends confidence that there is significant desire for increased collaboration across sectors; however, this would be enhanced by specific viewpoints from those sectors.

Limited Transportability Assessment

This study is very specific to concerns in large BC communities and the overall BC context. Care should be taken before assigning recommendations to other jurisdictions that may be further along in developing and implementing evidence-based approaches or are experiencing different types of social issues. The recommendations in this study focus on the acceptance of significant investment in support of vulnerable populations that will require governmental support at all levels, depending on the community or province.

Future Research

This study indicated that there was a desire to increase cross sectoral collaboration among police, social service, medical, and support agencies in BC in support of vulnerable populations. The motivations for that collaboration varied from agency to agency. In some cases, the motivation may be a reduction in police workload to allow for reallocation of resources to more serious crimes. In other cases, the motivation could be to increase overall

community wellbeing and support to vulnerable populations. Decriminalisation of illicit drugs was also an overarching theme in this study that was supported by all participants provided that substantial infrastructure and supports were in place prior to implementation. All of the motivations and approaches bear consideration for future research, especially within the Canadian context of police and criminal justice response to mental health as a result of deinstitutionalisation. There was limited research available to specifically identify why deinstitutionalisation has led to the current homeless crisis in many BC communities. As indicated by the participants, there was an understanding that supports were difficult to access, but the reasons behind this require more investigation. Furthermore, police and criminal justice data collection should be re-envisioned to consider a better understanding of specific upstream drivers of mental health behaviours, including specific data with respect to mental health calls for service beyond simple classification.

Chapter 8: Conclusion

Are police reluctant warriors in the battle against addictions, mental health illness, and homelessness? The results of this major paper indicated that they were indeed reluctant, not due to a lack of compassion or willingness to help, but because, in their view, criminal justice approaches to these concerns remain ineffective at resolving them. Police spend the majority of their response time dealing with non-chargeable occurrences, many of which involve vulnerable populations. Police, advocacy, and medical participants in this study expressed their frustration in the slow pace of change in developing effective solutions that focussed on meaningful support and interventions, based on the restoration of dignity and wellbeing in vulnerable populations.

Societal demands to eliminate the spectre of homelessness and behaviours deemed to be socially deviant have forced police agencies to fight a war that targets the wrong enemy. The current focus on vulnerable populations must be changed to target the root causes of those afflictions. Adverse experiences in childhood, physical and mental trauma, intergenerational trauma, poverty, poor access to supports, and stigmatisation all contribute to the degradation of people who should be supported, not vilified. Using police agencies to enforce politically expedient polices, as opposed to those designed to create overall wellbeing, place those agencies in a constant struggle between protecting the rights and freedoms of all citizens versus those of the vulnerable population.

Collaborative efforts, bolstered by significant financial investment, are required to allow police to focus on their primary mandate of public safety and wellbeing. Just as World War II was won through the collective will of the Allied Powers to a common goal of peace, so too will

the war on addictions, mental health, and homelessness be won through collaboration, investment, and collective will.

Appendix A: Interview Guide

Reluctant Warriors: Changing Police Perceptions in the War on Drugs, Homelessness, and Social Disorder

Interview Guide

1. What is your current position and how long have you been in this role?
2. What are your primary duties in your current position?
3. Could you describe your experience in dealing with marginalised or vulnerable populations with respect to:
    a. Addictions
    b. Mental health
    c. Homelessness
    d. Social disorder
4. Do you work directly with persons suffering from these issues or are you in more of a supervisor or policy development role?
5. What is your agency's mandate with respect to these social issues?
6. Do you believe that your organisation's mandate is aligned to the agency's actual practice?
7. In your opinion, to what extent do you feel your agency has been effective or ineffective in meeting its mandate on the following social issues, using the scale of very ineffective, somewhat ineffective, somewhat effective, or very effective with respect to vulnerable populations including:

a. Addictions

b. Mental health

c. Homelessness

d. Social disorder

8. WHY have you rated your agency the way you have?
9. In your experience, what do you believe are the major barriers to achieving your agency's mandate with respect to supporting:

    a. Addictions

    b. Mental health

    c. Homelessness

    d. Social disorder

10. If you feel that there is a need to develop alternatives to your agency's current practice, what, if any, do you think are the major barriers to producing effective policy alternatives to the current response to addictions, mental health, and homelessness ?
11. To what extent do you agree or disagree with the following policy alternatives:

    a. Decriminalisation or medicalisation of controlled drugs should take precedence over enforcement in vulnerable populations?

    b. Reducing stigmatisation is a key target for effective implementation of alternatives?

    c. Developing alternatives to police responses, such as co-responder models, is an important component of building well-being amongst vulnerable populations?

d. Developing alternatives to sentencing is an important component of building well-being in vulnerable populations? WHY?

12. What other alternatives would you recommend?

General open-ended questions:

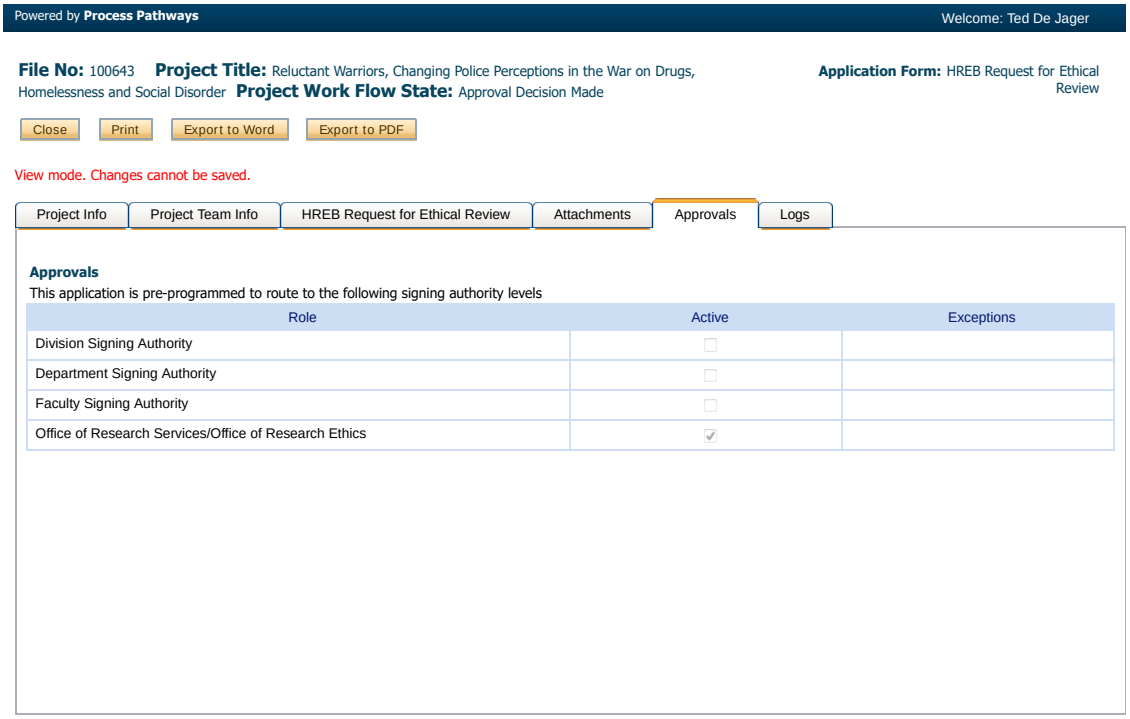
1. What is your view of the role of the police with respect to being first responders in matters of addiction, mental health, homelessness, and social disorder?
    a. Why do you feel this way?
    b. What should police do differently, if anything?
    c. Who else should be involved?
2. What are your overall views on Canadian drug policy?
3. What are your views on harm reduction measures? Treatment programs?
4. Where do you think police should focus their efforts with respect to illegal drugs? For instance, should they be seeking support for drug users while at the same time targeting importers and traffickers?
    a. How should resources be deployed?
    b. Who should be the targets of enforcement?
5. How should the police divide or allocate their efforts on drug dealers and criminal behaviour as opposed to street level possession?
6. In your opinion, how strongly do you agree or disagree with the following (use the scale of strongly agree, agree, neither agree nor disagree, disagree, strongly disagree)?
    a. Canadian drug policy should move towards decriminalisation of certain illegal drugs, particularly those at the street level? Why?

    b. Harm reduction efforts, such as safe consumption sites, are an important component of effective drug policy? Why?
    c. Treatment should be available on demand? What types?
7. In your opinion, how strongly do you agree or disagree that the four pillars approach of harm reduction, treatment, enforcement, and education has been effective, starting with:
    a. Harm reduction
    b. Treatment
    c. Enforcement
    d. Education
    e. Are each of these pillars still relevant or are there other approaches that can be more effective?
8. In your experience, are tough-on-crime approaches beneficial or harmful to someone experiencing a substance addiction?
9. In your experience, are harm reduction approaches beneficial or harmful to someone experiencing a substance addiction?
10. What would an ideal approach to mental health, homelessness, drug use, and addiction be?
11. In your opinion, what is the way forward to developing effective policy to support those suffering from addictions, homelessness, mental health, and social issues?

That concludes our interview. Is there anything else that you would like to share with me about these vulnerable populations?

Thank you for your time today.

Appendix B: Human Research Ethics Board Approval



Powered by **Process Pathways** Welcome: Ted De Jager

File No: 100643 **Project Title:** Reluctant Warriors, Changing Police Perceptions in the War on Drugs, Homelessness and Social Disorder **Project Work Flow State:** Approval Decision Made

Application Form: HREB Request for Ethical Review

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View mode. Changes cannot be saved.

Project Info | Project Team Info | HREB Request for Ethical Review | Attachments | Approvals | Logs

Approvals

This application is pre-programmed to route to the following signing authority levels

Role	Active	Exceptions
Division Signing Authority	☐	
Department Signing Authority	☐	
Faculty Signing Authority	☐	
Office of Research Services/Office of Research Ethics	☑	

Appendix C: Informed Consent Forms

Theodore.DeJager@student.ufv.ca

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November 2020

Reluctant Warriors: Changing Police Perceptions in the War on Drugs, Homelessness, and Social Disorder

Letter of Informed Consent

Purpose/Objectives of the Study

My name is Ted De Jager. I am a graduate student in the School of Criminology and Criminal Justice at the University of the Fraser Valley. I am conducting research for my final major paper into the perceptions of leaders in the fields of criminal justice, social justice, mental health and addictions, and social support. The intent of the research is to build context around data that indicate that over 60% of police calls for service are non-chargeable with respect to the Criminal Code of Canada. A significant portion of these calls for service deal with vulnerable populations, especially with respect to addictions, mental health, and homelessness. The intent of this project is to determine what policy options may exist to support these populations through increased medical and social support, as opposed to traditional police responses and criminal justice measures. This project is being supervised by Dr. Amanda McCormick and Dr. Irwin Cohen from the UFV School of Criminology and Criminal Justice.

Procedures involved in the Research

To provide context to the available data on police and criminal justice response to addictions, mental health, and social concerns, my intent is to interview practitioners across the spectrum of social support, ranging from criminal justice professionals to those in support of vulnerable populations. Given your professional experience with vulnerable populations and other support agencies, you are being invited to participate in this project as someone with field experience in the subject matter. The interview is designed to elicit your views on the topics of mental health and addictions, homelessness, decriminalisation or medicalisation of controlled drugs, and the

criminal justice approach to these issues. An important part of the interview will be your perceptions around stigmatisation of vulnerable populations and alternatives to support these populations outside of the criminal justice system. The interview, which is anticipated to take approximately 30 to 45 minutes of your time, will be audio recorded with your consent. If you do not wish to be audio recorded, the interviewer will take detailed notes during the interview, which you will be able to review upon request.

Interviews will be conducted using ZOOM, due to current COVID requirements. The recording function on ZOOM will not be used.

If you feel there are other people within your organisation or contacts who could provide additional context, they may express their interest to participate in this study by emailing me directly at Theodore.DeJager@student.ufv.ca

Potential Benefits

This project is designed to analyse current data with respect to social issues, such as homelessness, addictions, and mental health, particularly with respect to police responses and stigmatisation. Any information that you can share on these topics will provide further insight into these complex issues will help to inform the final recommendations made in the major paper.

Potential Harms, Risks, or Discomforts to Participants

There are no anticipated harms or discomforts associated with your participation in this research. Your personal views as a professional in your field are important to provide context to existing data. Any information that you feel could put you in a negative light, either with your agency or the public you serve, will be discussed during the interview to ensure your wishes are respected. You will be informed of the context of your statements, prior to the completion of the project. Your views will not be presented in a negative light, given that the interview is meant to gather your expertise with respect to alternatives to using the criminal justice system to address social issues.

Confidentiality

All information obtained during these interviews will remain confidential. Any information used in the major paper will be shared with you in advance to ensure an accurate summary of your information, and that it conforms to your expressed views. Information that you feel does not accurately reflect your views will be removed. Data for this project, including the audio recordings or the detailed notes taken during the interview, will be de-identified and subsequently destroyed by June 1, 2021. Data will be securely stored on an encrypted drive and on a personal computer. Your name will not be used in the major paper. Transcripts will be shredded and data stored on electronic devices will be securely deleted. Given the sampling method, it is possible that your identity may be ascertained by referring the research to

another participant, or through referral from another participant. Furthermore, your identity may be ascertained through the recognition of your already publicized views, even though information in the paper will be anonymised.

Participation

Your participation is voluntary and you may withdraw at any time without consequences, by email to Theodore.DeJager@student.ufv.ca . Participants who wish to withdraw, must do so prior to March 30, 2021, since the project will be presented one week after that date. Upon withdrawal, any information obtained from you will be returned to you if requested and copies destroyed. As an alternative to withdrawing fully from this project, you may choose to answer only some of the questions.

Study Results

The final version of the major paper will be presented to my advisors, both of whom are UFV professors (Dr. Amanda McCormick, Amanda.McCormick@ufv.ca and Dr. Irwin Cohen, Irwin.Cohen@ufv.ca). Once approved, the results will be presented to an examining committee, and may also be used as reference material for future studies or to publish or present in academic journals/conferences. You will receive a copy of the final report if desired by emailing me directly at Theodore.DeJager@student.ufv.ca

Questions

CONTACT FOR INFORMATION ABOUT THE STUDY

Please contact me directly if you have any questions about this study at Theodore.DeJager@student.ufv.ca

Alternatively, you may contact my supervisors, Dr. Amanda McCormick, Amanda.McCormick@ufv.ca or Dr. Irwin Cohen, Irwin.Cohen@ufv.ca .

CONTACT FOR CONCERNS

If you have any concerns regarding your rights or welfare as a participant in this research study, please contact the Ethics Officer at 604-557-4011 or Research.Ethics@ufv.ca.

The ethics of this research project have been reviewed and approved by the UFV Human Research Ethics Board on January 11, 2021, Protocol Number 100643.

Consent Form

By signing below, I agree to participate in this study, titled *Reluctant Warriors: Changing Police Perceptions in the War on Drugs, Homelessness, and Social Disorder*.

I have read the information presented in the letter of informed consent for the study being conducted by Ted De Jager at the University of the Fraser Valley. I have had the opportunity to ask questions about my involvement in this study and to receive any additional details.

I understand that I have the right to withdraw from the study at any time before March 30, 2021, and that confidentiality and/or anonymity of all results will be preserved. If I have any questions about the study, I should contact Ted De Jager at Theodore.DeJager@student.ufv.ca

If I have any concerns regarding my rights or welfare as a participant in this research study, I can contact the UFV Ethics Officer at 604-557-4011 or Research.Ethics@ufv.ca.

I consent to being audio recorded during this interview and have initialled this line to indicate my consent. The record function on ZOOM will not be used. If I do not wish to be audio recorded, I may be able to continue in the study by reviewing the notes of the researcher, Ted De Jager. Initial of participant_____

Name (please print) _____

Signature _____

Date _____

Once signed, you will receive a copy of this consent form.

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